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ABSTRACT

The 1970 annual report on the Oregon Migrant Health Project discusses health services for migrant agricultural workers and their families (approximately 30,000 individuals) who worked and lived temporarily in various Oregon counties. As noted, some 9,000 of the 30,000 migrants were estimated to be in need of some type of medical service. Thus, the basic objective involved providing migrants with acceptable and accessible medical and dental care, hospitalization, and preventive health services with the existing resources. Results presented in the document are divided into categories: medical services, hospital services, dental services, nursing services, sanitation services, health education services, and long- and short-term goals for improved nutrition. Statistics are given for 12 project counties, along with discussions of efforts made to attain project objectives. The report notes that the greatest need for funds related to dental care, eye-glasses, hospitalization, and inpatient physician's fees. (AN)

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OREGON MIGRANT HEALTH PROJECT

1970 Annual Report

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ADMINISTRATIVE STAFF

Oregon Migrant Health Project
Occupational Health Section
Preventive Medical Services Division
Oregon State Board of Health
1400 S.W. 5th Avenue
Portland, Oregon 97201

Project Director: Hugh E. Dierker, M.D., M.P.H.
Director
Occupational Health Section

Project Consultants:

Lois Epeneter, P.H.N.
Supervisory Nurse

Taylor Sandvigen
Farm Labor Health Consultant

Marion Kelsven, P.H.N.
Assistant Supervisory Nurse

Raymond Jorgensen
Assistant Supervisory Sanitarian

Sonja R. Kollias, M.P.H.
Health Education Consultant

ADMINISTRATIVE STAFF
OF
County Migrant Health Projects

Health Officer/Director	Supervisory Nurse	Supervisory Sanitarian
Clackamas County Hollister M. Stolte, M.D.	Helen Hill, P.H.N.	John M. Borden
Hood River County L. L. Hoffman, M.D.	JoAnn Oakes, P.H.N.	Noel P. McKeehan
Jackson County A. Erin Merkel, M.D.	Ethelmae Kanclier, P.H.N.	Orie S. Moore
Jefferson County C. K. Kemper	Doris Suratt, P.H.N.	John R. Kuhn
Klamath County Neil Black, M.D.	Myrtle Caldwell, P.H.N.	Willard Ostlund
Linn County John W. Guepe, M.D.	Anne Dunlap, P.H.N.	Fred A. Weber
Malheur County David W. Sarazin, M.D.	Edna Blaylock, P.H.N.	Ray Huff
Marion County Peter J. Batten, M.D.	Helen Murray, P.H.N.	C. S. Sherman
Polk County E. B. Bossatti, M.D.	Marie Swanson, P.H.N.	Ron Baker
Umatilla County Alton L. Alderman, M.D.	Jane Smith, P.H.N.	C. Evan Dillon
Washington County Harry Kemp	Patricia Williams, P.H.N.	Robert Brown
Yamhill County Lloyd E. Ragan, M.D.	Mildred Philippi, P.H.N.	Donald Rice

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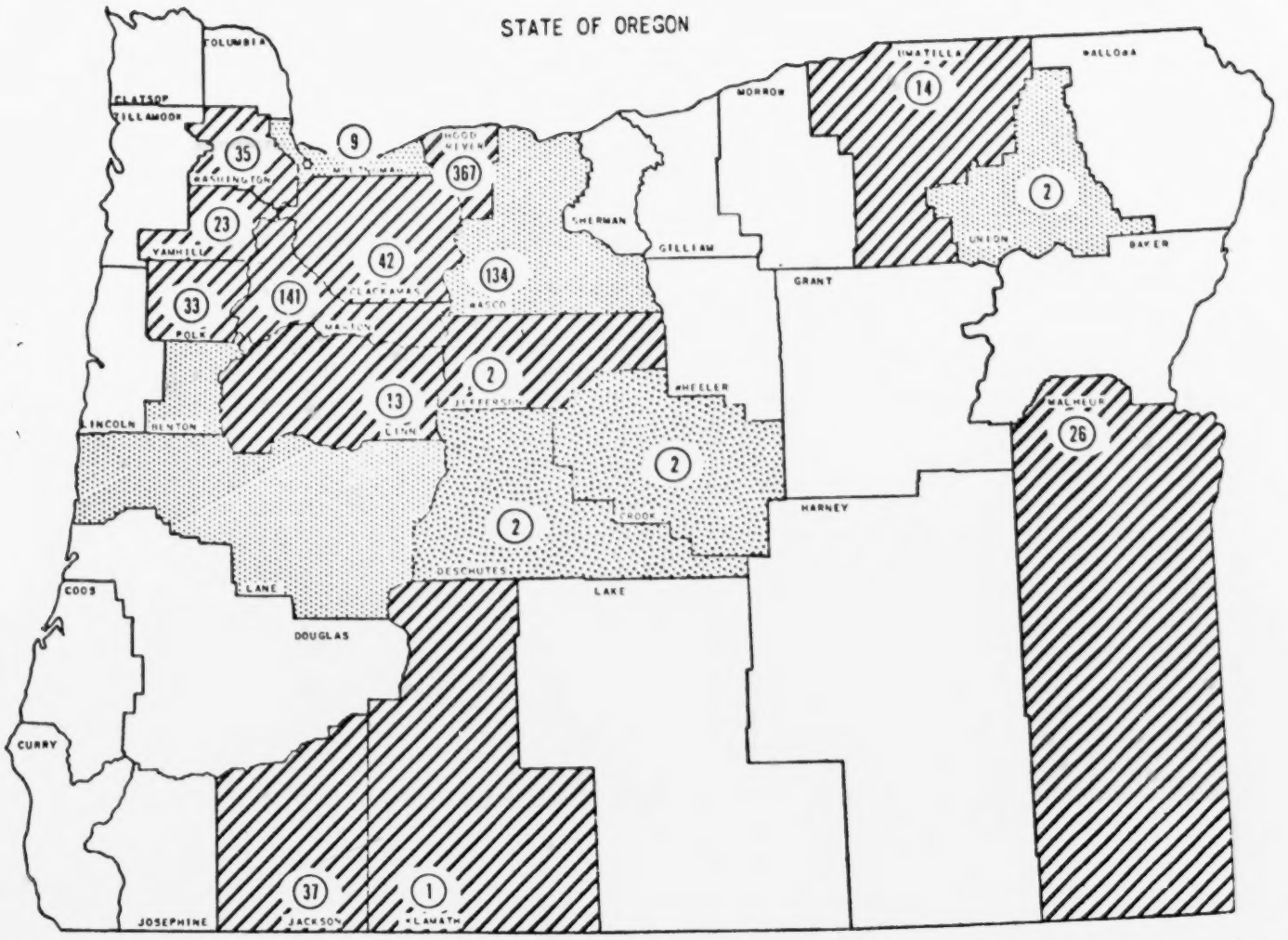
FOREWORD

Migrant agricultural workers and their families (approximately 30,000 individuals) work and live temporarily in 19 Oregon counties for varying lengths of time each year. The spring cherry harvest has a two to three week labor demand. Strawberries, cane berries and beans provide harvest work during the bulk of the summer, with tree fruit, potatoes, and onions requiring harvesters in the fall months. In addition, pre and post harvest work in the fields provide employment for migrants. Of the 18,694 migrants screened for health purposes, approximately 1,200 were seen in more than one county. In the 12 project counties, 58% of the families health screened were Mexican-American, 35% Anglo, and 7% Indians and Negroes. Oregon is becoming "home base" for an increasing number of migrants each year. County reports range from 10 families "wintering over" to 450 "home based" families.

Health services for the migrant agricultural workers and their families have been provided through the federally funded Oregon Migrant Health Project for eight years. When initially funded in 1963, three counties developed projects. By 1969, services had expanded to cover 14 of the 19 counties having migrant agricultural worker population. Shortage of funds allocated to Oregon, brought about by 1) the Public Health Service's priority funding of project development in other states, and 2) inflationary costs for staff, supplies, and services, required a curtailment in the provision of medical, hospital and dental care to migrants who needed these services. Cooperation and coordination with other resources helped financially in meeting a limited amount of the medical and dental needs. Especially helpful have been the Oregon Employment Service's Experimental and Demonstration Project and the Oregon Department of Education's Migrant Education Program (both federally funded). Other resources utilized have been state official agencies, voluntary associations, and local service groups, which have assisted in paying bills or have provided services for the medically indigent. The need for funds is greatest for dental care, eye glasses, hospitalization and inpatient physician's fees, as there are not other resources available, such as Title XIX.

Innovations in the provision of services through the Oregon Migrant Health Project have resulted in 1) greater involvement of migrants or migrant representatives in planning and implementing health services and 2) expanded clinic services in two project areas. Efforts continue to be made to help develop better rural and migrant health services via multiple funding, regional planning, and involvement of consumers.

The following 1970 progress report covers the period from December 1, 1969 to November 30, 1970. The report is presented on a POME basis with supportive data and narratives. Individual reports providing detailed information of the 12 project counties are under separate cover.



Project Counties with migrant population

(#) Number of farm labor camps

Non-project counties with migrant population

1970 OREGON MIGRANT HEALTH PROJECT

PROBLEM:

Migrant agricultural workers and their families (approximately 30,000 individuals) work and live temporarily in 19 Oregon counties for varying lengths of time each year. In addition, Oregon is becoming "home base" for an increasing number of migrants, indicated by counties reporting of from 10 to 450 families either "wintering over" or "home based". In 12 counties, 58% of the 18,694 individuals evaluated for health needs were Mexican-American, 35% Anglo, and 7% Indians and Negroes. Approximately 47% of the individuals evaluated were 0 to 14 years of age, with 44% in the 15 to 44 years of age category. The migrants live in approximately 850 farm labor camps, 19% of which do not meet minimum standards of sanitation. Approximately 30% of the fields in which they work do not have adequate drinking water or toilet facilities. Medical, dental, and preventive health resources are not readily accessible in most of the areas in which migrants work. The available resources are not consistently sought or utilized by the migrant agricultural workers and their families. Lack of medical and dental treatment results in physical and mental stress and a potentially severe economic loss to the individual and his family. The resultant economic impact on the community, due to workers' illness, is reflected in loss of agricultural profits, increased public welfare case load, and an increased financial loss to community hospitals, physicians, and dentists. Oregon is one of the few states which does not provide state funds to local county health departments. As a result, local governments cannot assume the costs of, nor meet, the migrants' health needs without support of federal funds. Approximately 9,000 of the 30,000 migrants are estimated to be in need of some type of medical service, based upon the fact that 30% or 5,580 of the 18,694 individuals evaluated for health needs needed and/or received medical service of some type in 1970.

OBJECTIVE:

To assure that acceptable and accessible medical and dental care, hospitalization and preventive health services are provided within existing resources to as many agricultural workers and their families as possible.

METHODS:	RESULTS:	
1. Review health needs of migrants, develop plans to meet these needs, and evaluate the effectiveness of such plans.	1. Plans developed.	12
	Plans evaluated.	12
2. Provide direct services to two local projects, and consultation to assist all project staffs in implementing and evaluating plans to provide services to migrant agricultural workers and their families.	2. Consultations provided	1,581
	Counties provided direct services. . . .	2
3. Provide training to health department staffs regarding nursing, sanitation, and health education procedures.	3. Workshops conducted.	5
	Field training sessions conducted. . . .	136
4. Develop and provide health information materials related to priority health problems of migrants.	4. Pamphlets - posters developed.	5
	Counties provided films and pamphlets. .	9
5. Utilize all resources to assist in meeting the physical and mental health needs of the migrant.	5. Consultation with agencies and groups. .	378
	Agencies and groups involved in planning	23
	Agencies and groups providing services .	17
	Agencies and groups providing funds. . .	14
	Referrals made to medical resources for care	6,096
6. Establish uniform record systems and provide a transfer of records for continuity of care.	6. Record systems established	12
	Interstate referrals sent	156
	Interstate referrals received.	28
	Care completed for those referred. . . .	57
7. Maintain outreach services and evaluation of individual's health needs through family visits.	7. Individual migrants evaluated for health needs and provided outreach services . .	18,694
8. Obtain medical care for 2,500 individuals in private physicians' offices, and for 4,000 in clinics.	8. Migrants obtaining care in private physicians' offices (paid by project funds).	2,994
	Migrants obtaining care in clinics. . .	2,459
9. Provide nursing follow-up of treatment for migrants receiving medical care.	9. Related nursing visits in 7 counties. .	2,462
10. Provide dental screening and dental health education for 1,500 children attending migrant summer schools in eight project counties, and dental care for 1,000 of those children.	10. Screenings and instruction provided . .	1,433
	Prophylactic fluoride applications. . .	1,073
	Migrant children receiving dental care (See dental report)	
11. Provide dental care for 600 migrant adults and children not included in school program.	11. Migrants receiving dental care.	894
12. Obtain short-term hospitalization for 360 individuals paid for in part by project funds.	12. Hospitalizations.	354
	Hospitalizations paid in part by project	214
13. Conduct vision and hearing evaluations on 1,500 migrant children attending summer schools in project counties; provide follow-up for those needing care.	13. Hearing evaluations conducted	463
	Migrants referred	37
	Vision evaluations conducted.	424
	Migrants referred	22
14. Provide counseling for specific health problems to 10,000 individuals.	14. Consultations provided.	12,711

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15.	Encourage use of the family health record and see that all pertinent medical information is entered onto this record whenever services are rendered.	15.	Family health records provided. 3,054
16.	Intensify accident prevention programs to decrease the number of accidents occurring in farm labor camps and homes.	16.	Accidents occurring in 1969 . . . . . 489 Accidents occurring in 1970 438
17.	Establish migrant health advisory committees.	17.	Counties establishing advisory committee 6
18.	Provide follow-up for certain chronic conditions.	18.	Known cases of Tuberculosis . . . . . 258 TB cases receiving medical follow-up. . 38 Known cases of Diabetes . . . . . 195 Diabetes cases receiving medical follow-up. . . . . 113 Known cases of Epilepsy . . . . . 113 Epilepsy cases receiving medical follow-up. 42
19.	Ascertain compliance with the Farm Labor Camp Statutes and Regulations by performing camp inspections and follow-up visits of the 624 camps in project areas.	19.	Inspections and follow-up visits made . 2,305
20.	To obtain compliance with the existing standards by: a. Bringing those camps (223) whose facilities do not meet existing standards up to an acceptable level; b. Obtaining the closure of those camps whose operators indicate they are not willing to make necessary facility provisions; c. Assure the maintenance of farm labor camps by obtaining compliance with the existing standards or obtaining closure of the camps.	20.	a. Camps brought into compliance prior to or immediately subsequent to opening. . . . . 85 b. Camps closed immediately after opening. . . . . 16 Camps never opened . . . . . 46 c. Camps closed due to lack of maintenance. 17
21.	To observe the provision of a potable water supply and sanitary toilet facilities at the fields where the farm workers are employed.	21.	Field water supplies checked. . . . . 526 Defective water supplies. . . . . 196 Defective water supplies corrected. . . 91 Fields inspected for toilet facilities. 494 Fields with defective toilet facilities 353 Fields correcting defective toilet facilities. 184
22.	To recruit bilingual personnel to work in those project areas where there are large concentrations of Spanish speaking migrants.	22.	County projects employing bilingual staff . . . . . 10 Bilingual personnel employed. 19

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MEDICAL SERVICES

To assure that migrant workers and their families receive needed primary medical care, the migrant project provides funds for out-patient medical care, limited dental care, and partial payment for short-term hospitalization when other funding is not available. In the majority of our project counties, medical care is provided on a fee-for-service basis by local physicians in their offices. The patients have their choice of the physician they wish to see. Many of the migrants have expressed their preference for this type of service and have established a personal rapport with "their doctor"--returning to him each time care is needed. Since many families return to the same work area each year, they have been seeing the same physician for a number of years. Three counties, Marion, Yamhill, and Washington, provided services in evening family clinics which were augmented by referrals to private physicians when the clinics were closed or when specialized care was indicated. Marion and Washington County migrant clinics were held only during the harvest season. The Yamhill County clinic now provides a year-round service with clinics offered one night a week during the winter.

With good cooperation and interest by the physicians, dentists, hospitals, pharmacies, local agencies and service groups, the care provided, so far, has been fairly adequate. However, while verified unmet needs are relatively few, increased cost of medical services and reduced funding could curtail the amount and kinds of services provided. One area of unmet need is in the provision of glasses. Migrant funds are not provided to meet this need. Children, who are enrolled in the Migrant Summer School Program, are provided this service from Title I funds, but for other children and adults it is very difficult to find other sources of funding. Patients on general welfare assistance or under a Title XIX categorical grant may receive payment for needed glasses from those funds. Otherwise, limited assistance has been obtained from local service groups such as the Elks Club, Lions Club, and church groups. For example, in one county with nine vision referrals, funding for eight pair of glasses was obtained from local service organizations.

All available local resources are used to supplement the limited project funds available for medical services. These are often services provided to the entire community by the local health departments or other agencies. Regular family planning, tuberculosis, immunization, well-child, venereal disease, otology, and mental health clinics are utilized by migrant families. Use of these services is somewhat limited because of their time scheduling which often conflicts with patient's working hours and other factors such as transportation problems often make it impossible for patients to keep appointments. The following table shows such services in the various project counties:

County	Immunizations	Family Planning	V.D. Exam. Treatment	T.B.	Well Child Conference	Mental Health Clinics	Otology Clinics
Clackamas	All ages	Yes	Yes	Yes	Yes	Separate Agency	Yes
Hood River	Pre-School & School	No	Limited	Yes	No	Yes	Yes
Jackson	All ages	Yes	Yes	Yes	Yes	Yes	Yes
Jefferson	All ages	No	No	Yes	No	Yes	Yes
Klamath	All ages	Yes	Yes	Yes	Yes	Yes	No
Linn	All ages	No	Yes	Yes	No	Separate Agency	Yes
Malheur	All ages	No	Limited	Yes	No	Separate Agency	Yes
Marion	All ages	Yes	Yes	Yes	Yes	Yes	Yes
Polk	All ages	Yes	Limited	Yes	Yes	Separate Agency	Yes
Umatilla	All ages	Yes	Yes	Yes	Yes	Yes	Yes
Washington	All ages	Yes	Yes	Yes	Limited	Separate Agency	Yes
Yamhill	All ages	Yes	Yes	Yes	No	Yes	Yes

Of the 18,694 individuals screened for all health problems by the project nurse or her aides, 5,580 or 31% of these individuals needed and received some type of medical services. This represents a total of 9,855 individual visits. In addition, screening services and referrals for special conditions and examinations without sickness were made. Some individuals referred for medical services were also included in the special examination and screening services. Following are tables showing data relating to screening and special examination services.

OREGON PROJECT COUNTIES, 1970

REFERRAL FOR SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS

County	Family Planning Services		Well Child Care		Prenatal Care		Post-partum Care		Tuberculosis Followup Inactive Case		Medical-Surgical Aftercare	
	TV*	TI**	TV	TI	TV	TI	TV	TI	TV	TI	TV	TI
Clackamas	11	11	2	2	9	9	0	0	2	2	4	4
Hood River	37	35	36	33	52	25	13	13	10	7	-	29
Jackson	12	4	0	0	-	3	0	0	-	4	-	6
Jefferson	14	14	0	0	15	15	0	0	1	1	4	4
Klamath	3	3	0	0	14	6	0	0	2	2	5	1
Linn	30	30	40	40	30	30	15	15	8	8	10	10
Malheur	-	17	-	26	-	39	-	31	-	47	-	26
Marion	92	75	30	25	113	66	-	12	20	13	-	116
Polk	12	12	8	6	9	9	2	2	2	2	6	6
Umatilla	21	21	46	20	36	20	6	6	2	2	3	3
Washington	31	31	6	6	19	19	9	9	0	0	1	1
Yamhill	49	25	0	0	53	33	0	0	0	0	0	0
Total		278		158		274		88		88		206

*TV: Total Visits
**TI: Total Individuals

County	General Physical Exam		Pap Smears		Tuberculin Testing		Serology		Vision		Auditory		Chest X-rays		Other ***	
	TV	TI	TV	TI	TV	TI	TV	TI	TV	TI	TV	TI	TV	TI	TV	TI
Clackamas	0	0	3	3	0	0	3	3	4	4	0	0	0	0	0	0
Hood River	39	39	5	5	106	106	32	32	39	39	21	21	7	7	37	37
Jackson	0	0	-	4	-	12	0	0	0	0	0	0	-	7	-	1
Jefferson	1	1	1	1	0	0	0	0	0	0	0	0	0	0	-	595
Klamath	0	0	3	3	10	10	0	0	0	0	0	0	0	0	0	0
Linn	31	31	12	12	15	15	31	31	98	98	98	98	26	20	7	7
Malheur	-	22	-	24	-	556	-	6	-	352	-	648	-	40	-	542
Marion	800	800	161	159	317	315	535	529	445	445	250	244	460	454	1622	1588
Polk	17	16	12	12	6	6	11	11	27	27	28	28	18	18	12	12
Umatilla	4	4	5	5	6	6	0	0	0	0	0	0	3	3	0	0
Washington	1	1	10	10	97	97	0	0	52	52	51	51	1	1	1561	1561
Yamhill	154	105	45	45	121	121	0	0	157	157	15	15	0	0	0	0
Total		1019		283		1244		612		1174		1105		550		4343

*** See individual county reports for explanation of "other"

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In addition to local health services utilized by the migrant program, the University of Oregon Medical School through its clinical facilities and hospitals provided much medical care. Statistical data on numbers of patients seen and cared for in these facilities are not available. Some difficulty was encountered at the Medical School this summer in arranging for appointments because of increased case load (medically indigent because of unemployment) and decreased summer staffing. Portland's Providence and Emanuel Hospitals have provided some care through their residency training programs. The Devers Memorial Eye Clinic, Shriners Hospital for Crippled Children, the Crippled Children's Division, and various state hospitals (mental and tuberculosis) provided care for patients needing their specialized type of service without cost to the patients or the project.

DIAGNOSED AND/OR
MEDICAL CONDITIONS TREATED BY PHYSICIANS IN CLINICS, HEALTH DEPARTMENTS, HOSPITAL EMERGENCY ROOMS AND PHYSICIANS OFFICES, BY OREGON PROJECT COUNTY, 1970

COUNTIES	MEDICAL CONDITIONS: Infective and Parasitic Diseases	Neoplasms	Endocrine Nutritional & Metabolic	Diseases of the Blood and Blood Forming Organs	Mental Disorders	Diseases of the Nervous System & Sense Organs	Diseases of the Circulatory System	Diseases of the Respiratory System	Diseases of the Digestive System	Diseases of the Genitourinary System	Complications of Pregnancy, Childbirth and the Puerperium	Diseases of the Skin and Subcutaneous Tissue	Diseases of the Musculoskeletal System and Connective Tissue	Congenital Anomalies	Perinatal Morbidity & Mortality	Symptoms and Ill-Defined Conditions	Accidents, Poisonings, Violence	Total of All Conditions
CLACKAMAS	11	1	6	2	1	26	5	35	42	14	1	30	3	0	0	7	5	189
HOOD RIVER	63	1	13	5	11	21	21	86	45	41	5	40	11	3	1	22	56	445
JACKSON	4	2	2	1	1	3	2	12	8	2	0	7	3	0	0	2	11	60
KLAMATH	13	0	2	6	0	5	6	36	37	9	0	11	3	0	0	0	16	144
LINN	54	2	17	3	7	57	17	93	66	39	17	30	15	5	4	39	13	478
MALHEUR	73	7	35	4	5	36	26	171	423	38	4	67	15	2	1	33	36	976
MARION	91	15	65	29	57	189	98	321	156	132	18	168	39	3	0	115	187	1683
POLK	16	1	13	1	0	10	6	29	64	4	0	12	6	2	0	7	14	185
TRI-COUNTY	15	0	6	1	4	10	2	79	15	4	9	76	5	1	2	17	6	252
UMATILLA	16	0	8	0	1	17	2	33	3	18	0	19	2	1	0	11	11	142
WASHINGTON	124	2	22	5	12	61	20	208	79	51	12	51	19	2	0	65	21	754
YAMHILL	17	2	25	2	17	97	13	163	75	47	0	136	44	4	0	11	62	715
TOTAL	497	33	214	59	116	532	218	1266	1013	399	66	647	165	23	8	329	438	6023

The preceding table shows diagnosed and/or medical conditions treated by physicians in clinics, health departments, hospital emergency rooms, or physician's offices. The majority of these are acute medical problems. Cursory examination of the table indicates about 20% of those seen were for diseases of the respiratory tract. In addition, a large number of accidents (not work related), ear infections, skin conditions, other infections, and diseases of the digestive system may indicate areas of need for more health education as a preventive measure.

Chronic conditions, (such as epilepsy, diabetes, and tuberculosis) especially need continuity of care for effectiveness of control and regularity of medication, diet, etc., if these patients are to function at maximum capacity. Special effort is made to follow such patients regularly and to provide (through a referral system and personal medical records provided to patients) for the best continuity of care that patient's mobility allows. For tuberculosis control, attempts are made to correlate our program with other state and agency programs to provide regularity of medical surveillance of known tuberculosis patients by exchange of medical information. If a "check-up" is needed while the patient is in Oregon, arrangements are made for a chest clinic appointment, or at least for an X-ray. The results of these examinations and any recommendations are forwarded to the care agency at their home base. This type of follow-up includes patients on prophalactic drugs. Mass tuberculin testing is not done. Testing is done on case contacts and their families and on anyone with indicative symptoms or history of contact. This year 1,220 tuberculosis tests were given. Of these, 106 were positive; 1,099 were negative (see county reports). Close cooperation with the Oregon State Board of Health, Tuberculosis Control Section, has been mutually beneficial in providing tuberculosis surveillance.

A master migrant file of approximately 10,000 family cards is maintained in the state office and provides a "tickler" file on known chronic disease patients. This is an aid to the local project staffs in providing medical surveillance of these patients.

A report on dental services and hospitalization as a part of primary medical care is discussed later in this report.

Emphasis on preventive measures has always been a priority in working with migrant families. Prenatal care, nutritional needs, immunization, dental care, and accident prevention are areas which will be increasingly stressed in the coming year.

Immunizations are usually given in the regular health department clinics, migrant clinics, or in some cases at well-child clinics. More interest and cooperation were shown in getting immunizations this year. Immunizations were often requested by migrants themselves since many of them came from the South Texas area where polio and diphtheria epidemics occurred this year. Records of their immunizations are provided to migrant families, but past experience has shown that such records are seldom carried and it is difficult to determine the level of immunization on these people. Following is a table of the kinds and numbers of immunizations given.

	Completed Immunizations By Age					Incomplete Series	Boosters, Revaccinations
	Total	Under 1 Year	1-4	5-14	15 & Older		
	1542	180	421	846	95	1067	354
Smallpox	85	2	33	47	3		
Diphtheria	196	41	65	67	23	443	14
Tetanus	233	48	55	101	29	372	126
Polio	475	68	71	329	7	224	123
Typhoid	6			5	1	1	84
Measles	270	6	124	140			1
Other:							
Rubella	186	3	45	120	18		
Pertussis	68	12	27	29		27	5
Flu	4				4		
Hypertet	1			1			
Rabies	10				10		1
Mumps	8		1	7			

*Statistics unavailable for one county.

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In cooperation with the Oregon State Board of Health, Maternal and Child Health Section's Hearing and Vision Conservation Programs, approximately 460 migrant children received vision and/or hearing screening. The migrant project attempted follow-up on those requiring further care. Because the screening was so late "in the season", adequate treatment or correction was not possible on all of the referrals. The following is a summary of screening done by the vision and hearing personnel. This does not include vision and hearing screening done by other sources such as in migrant clinics.

Oregon State Board of Health

Division of Preventive Medical Services
Maternal and Child Health Section

Hearing and Vision Conservation Programs
MIGRANT SUMMARY
Spring and Summer, 1970

County	Preschool Hearing Screening					Preschool Vision Screening				
	Pure Tone Test	Unable To Test	School Age	Total Seen	Number Referred	Snellen Test	Allen Test	Unable To Test	Total Seen	Number Referred
Linn	88	6		94	16	76	13	2	91	9
Malheur	304	24		328	16	298	13	13	324	12
Marion	42			42	2					
Wasco-Sherman	29			29	3	24		5	29	1
TOTALS:	463	30		493	37	398	26	20	444	22

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HOSPITAL SERVICES

The hospital component has been and continues to be a very vital part of providing health care for migrant workers in Oregon. A total of 214 patients, including newborns, received partial payment of hospitalization through project funds. The majority of these were for acute medical problems and deliveries.

There were very few cases of elective surgery because: 1) migrants were reluctant to take time off from work during the busy harvest seasons; 2) project funds could help with only about half of the cost, migrants were unwilling to assume debts that they could not pay; and 3) other sources of financial aid were extremely limited.

Every effort is made to utilize existing resources before using project funds. Sources utilized in the Portland area include the University of Oregon Medical School Hospital, Devers Eye Clinic, Shriners Hospital, Veterans Hospital, and the resident programs at Portland Hospitals. In some cases assistance has been obtained from Welfare, Motor Vehicle Accident Fund, Workmen's Compensation, or other accident insurance. Some migrants have paid their own bills or at least a portion of them. However, in many instances there is no source for financial payment.

Though statistics are incomplete on migrant hospitalizations not paid from project funds, it is known that at least 140 other patients received care, utilizing the above-named resources for a portion of these, though some were unable to find any financial assistance or to pay the bill themselves. It is known that at least 29 individuals who needed assistance for hospitalization (20 of these for deliveries) could find no resource and there were insufficient project funds for them.

The phasing out of the hospital component of the project is a cause of deep concern in this state because:

1. Title 19 funds are available only if eligibility requirements are met for the Public Welfare categories of Aid to Dependent Children, Old Age Assistance, Aid to the Blind, or Aid to the Disabled.
2. General Welfare assistance cannot pay hospitalization costs unless the family is already receiving a general assistance grant. Few migrants are on general assistance except for short periods of time between harvests.
3. Although in a few cases migrant families have been able to secure Welfare assistance during the course of an illness, funds are not retroactive to pay hospitalization costs already incurred.
4. A heavy financial burden must be borne by the small rural community hospital where migrants are too far from the afore-mentioned facilities located in Portland.

The following tables show the hospital services given and the costs to the project.

HOSPITALIZATIONS WITH PARTIAL PAYMENT BY PROJECT FUNDS
December 1, 1969 - November 30, 1970

County	Number Patients	M	F	Age Grouping: Under 1	1-4	5-14	15-44	45-64	65+	Total Hosp. Days	Ave. Hosp. Days	Total Hospital Bill*	Paid by Project: Hospital Bill	Paid by Project: Physicians Fee
Clackamas	0	0	0	0	0	0	0	0	0	0	0			
Hood River	28	13	15	8	2	2	12	4	0	82	2.9	5070.09	2522.11	1390.00
Jackson	11	4	7	0	0	3	6	2	0	34	3.1	3541.14	1829.69	828.43
Jefferson	7	3	4	1	0	1	4	1	0	19	2.8	2230.90	1188.50	1277.25
Klamath	8	4	4	4	0	0	4	0	0	33	4.1	2022.95	1015.57	697.00
Linn	33	9	24	10	3	4	13	2	1	115	3.5	6916.95	3254.26	2635.00
Malheur	47	18	29	11	3	8	20	5	0	224	4.8	18,082.41	9752.55	5177.00
Marion	58	20	38	17	5	4	26	6	0	229	3.9	19,546.73	9203.59	5011.75
Polk	9	2	7	2	0	2	5	0	0	50	5.6	3780.78	1764.79	1705.00
Umatilla	7	2	5	3	0	0	4	0	0	49	7.0	2674.55	1273.95	390.00
Washington	6	4	2	0	1	1	4	0	0	14	2.3	1437.95	618.59	629.75
Yamhill	0	(Emergency Hospitalization Component Only)												
Total	214	79	135	56	14	25	98	20	1	849	3.9	65,274.45	32,453.50	19,941.18

OTHER HOSPITALIZATIONS NOT PAID BY PROJECT FUNDS
December 1, 1969 - November 30, 1970

County	Number Patients	M	F	Age Grouping: Under 1	1-4	5-14	15-44	45-64	65+	Total Hosp. Days
Clackamas	10	6	4	2	0	5	3	0	0	60
Hood River	24	16	8	4	1	0	18	1	0	NA
Jackson	(No figures available)									
Jefferson	1	0	1	0	0	0	1	0	0	26
Klamath	3	0	3	0	0	0	1	2	0	NA
Linn	(No figures available)									
Malheur	59	20	39	4	2	6	41	4	2	228
Marion	13	6	7	0	0	3	6	4	0	NA
Polk	6	3	3	1	0	0	3	2	0	38
Umatilla	2	1	1	0	0	0	2	0	0	NA
Washington	7	2	5	1	1	0	4	1	0	NA
Yamhill	15	6	9	0	2	3	7	2	1	148
Total	140	60	80	12	6	17	86	16	3	NA

*Does not include physicians' fees which are paid in full by the project.

SURGICAL PROCEDURES*

(Includes diagnostic radiology and non-surgical procedures)

Ophthalmology 3
- Operation on lens and vitreous - 1
- Operations on conjunctiva - 2

Otorhinolaryngology 6
- Operations on middle ear - 3
- Operations on pharynx, tonsils and adenoids - 3

Vascular and Cardiac Surgery 1
- Operations on peripheral blood vessels - 1

Thoracic Surgery 1
- Operations on chest wall, pleura and medeastinum - 1

Abdominal Surgery 17
- Repair of hernia - 2
- Incision and excision of abdominal wall region - 1
- Operations on appendix - 9
- Operations on biliary tract - 2
- Operations on stomach - 1
- Incision, excision, resection and enterostomy of intestines - 2

Urological Surgery 1
- Operation on scrotum and contents - 1

Gynecological Surgery 7
- Operations on fallopian tubes - 5
- Other operations on uterus and supporting structures - 1
- Operations on the breast - 1

Orthopedic Surgery 6
- Reduction of fracture and fracture-dislocations of ankle and wrist - 4
- Reduction of other fractures and fracture-dislocations - 2

Plastic Surgery 5
- Operations on skin and subcutaneous tissue - 1
- Biopsy - 2
- Diagnostic radiology - 1
- Other non-surgical procedures - 1

Total 47

*If more than one surgical procedure was performed, they are listed separately.

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HOSPITALIZATIONS - DECEMBER 1, 1969 - NOVEMBER 30, 1970

For all project counties in which migrant project funds were used.
Total number of hospitalizations (including newborns) - 217.
Migrant project monies paid to community hospitals in partial payment for migrant hospitalizations - $31,762.11.

CLASSIFICATION OF DIAGNOSES BY SYSTEMS OR CATEGORIES (ICD)*

I. INFECTIVE & PARASITIC DISEASES 5
- Enteritis (viral) - 3
- Diarrheal disease - 1
- Venereal disease (Not specified) - 1

II. NEOPLASMS. 1
- Benign (respiratory) - 1

III. ENDOCRINE, NUTRITIONAL, & METABOLIC DISEASES 7
- Diabetis Mellitus - 4
- Nutritional deficiency - 1
- Obesity (Not endocrine origin) - 2

IV. DISEASES OF BLOOD & BLOOD-FORMING ORGANS 1
- Iron deficiency anemias - 1

V. MENTAL DISORDERS 4
- Neuroses - 3
- Alcoholism - 1

VI. DISEASES OF THE NERVOUS SYSTEM & SENSE ORGANS. 13
- Meningitis - 1
- Epilepsy - 1
- Other spinal cord disease - 1
- Diseases of eye (pterygium - 2, cataract - 1) - 3
- Diseases of ear (otitis media - 6, other - 1) - 7

VII. DISEASES OF THE CIRCULATORY SYSTEM 6
- Hypertensive Heart disease - 1
- Ischemic Health disease - 1
- Ill-defined cerebrovascular disease - 2
- Varicose veins (lower extremities) - 2

VIII. DISEASES OF THE RESPIRATORY SYSTEM 38
- Acute respiratory infections (pharyngitis - 2, tonsilitis - 7, bronchitis - 5, other - 3) - 17

IX. DISEASES OF THE DIGESTIVE TRACT. 27
- Diseases of esophagus, stomach & duodenum (ulcers - 3, gastritis - 1) - 4
- Appendicitis - 9
- Hernias - 4
- Diseases of intestines (gastroenteritis - 4, intestinal obstruction - 1, other - 2) - 7
- Cholecystitis and/or cholelethiasis - 4

X. DISEASES OF THE GENITO-URINARY SYSTEM. 10
- Diseases of urinary tract - 1
- Diseases of female genital organs - 4
- Disorders of menstruation - 3
- Chronic disease of the breast - 2

XI. COMPLICATIONS OF PREGNANCY, CHILDBIRTH, & THE PUERPERIUM 54
- Complications of pregnancy (hyperemesis gravidarium - 2, hemorrhage - 1, false labor - 2) - 5
- Abortions - 3
- Delivery:
  - At term (single 39, twins 1 pair) - 41
  - Premature (single 3, twins 1 pair) - 5

XII. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE 12
- Skin infection - 1

XIV. CONGENITAL ANOMALIES 2
- Hydrocephalus - 1
- Genital organs - 1

XV. CAUSES OF PERINATAL MORBIDITY & MORTALITY. 1
- Hemalytic Disease of newborn - 1

XVI. SYMPTOMS AND ILL-DEFINED CONDITIONS. 14
- Symptoms referable to abdomen - 2
- Symptoms referable to genito-urinary system - 1
- Symptoms referable lymph system - 1
- Headache - 1
- Other general, ill-defined symptoms - 9

XVII. ACCIDENTS, POISONINGS, & VIOLENCE. 31
- Fractures & dislocations - 9
- Burns - 2
- Lacerations, contusions & concussions - 17
- Sprains & strains - 2
- Adverse effects of drugs, medicants, etc. - 1

CAUSES OF DEATH - 5
- 1 - Dehydration with electrolyte imbalance due to enteritis - female age 2 months.
- 1 - Acute heart failure & hyaline membrane disease - male age 12 hours.
- 1 - Pneumococcic Meningitis - female age 16 years.
- 1 - Pneumonia & septicemia - male age 7 months.
- 1 - Cardiovascular Accident - female age 40 years.

*If more than one diagnosis is given, each condition is coded separately.

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DENTAL SERVICES

Providing dental care as a part of primary medical care is one area of migrant need which is not being met. Present funding allows for only emergency care and a small amount of limited restorative care. In retrospect even the requested dental budget would have been inadequate and the awarded amount (about 25% less than requested) further reduced the amount of care that could have been given. Most dental care was given on a fee-for-service basis in private dental offices. Some service was provided in one county migrant family clinic. A total of 894 individuals received some care but not all of these cases were completed. Another 2,134 needed but did not receive care either because of lack of funds or because they left the area before care could be arranged. Some confusion in recording resulted in inaccurate data regarding total numbers of individuals screened. Our estimate would be close to 3,000. No attempt was made to provide dentures, partial plates or bridges.

Legislation is being introduced into the Oregon Legislature this session to permit dental students to work under a preceptorship program such as the program for medical students. Approved, and hopefully this will be, plans are being formulated to set up some dental clinics to increase dental services available to migrant families.

In cooperation with the Dental Health Section of the Oregon State Board of Health and four employed dental students, a dental health survey was conducted in the Migrant Summer Schools. These summer schools, funded under Title I, included not only migrant children but children in the "Head Start" program. All children were screened. Dr. David Witter, Director of the Dental Health Section, and Dr. Robert Huffman, Public Health dentist, planned and provided student supervision for this screening and dental health education service. Working with the Oregon Migrant Education Service Center, details, such as time schedules, were worked out. In addition to the summer schools screened by the Dental Health Section team, one large eastern Oregon migrant summer school provided its own dental screening. In this school an additional 350 children were seen.

To quote from Dr. Witter's summary of the dental survey:

"The objectives of the Migrant Dental Survey were twofold; it provided screening and dental education. The screening portion was designed to document the dental need of the migrant population, to establish a basis for dental care funding. In addition, a priority system regarding individual need was established to provide optimum utilization of current dental funds for treating migrants. The dental education portion of the program emphasized toothbrushing techniques and an awareness of the importance of oral hygiene.

"The screening was conducted either in the Summer School Program for migrant children (on all children present) or within migrant camps on a voluntary basis. Conditions in the schools allowed a detailed examination with explorers and mouth mirrors. Here each tooth and tooth surface was examined and recorded. Also, an oral hygiene index (OHI) was determined on each child to reflect level of oral hygiene practices. At the time of the examination or during the educational program, toothbrushes were given to each child, followed by toothbrush instruction (TBI) and a self-applied fluoride paste. The facilities within the camps limited the screening to tongue depressors only."

On examination, those needing care were classified as to urgency of dental care. Following is a table showing the distribution of persons in each category:

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DISTRIBUTION OF PERSONS SCREENED
AS TO URGENCY OF DENTAL NEEDS

Migrant Dental Health Project, Summer 1970

Table 2

Summer School Inspection Program:

	NUMBER	0 NO.	0 PERCENT	1-2 NO.	1-2 PERCENT	3-4 NO.	3-4 PERCENT
Migrant	688	139	20.2%	408	59.3%	141	20.5%
Head Start	215	68	31.6	110	51.2	37	17.2
Other	170	43	25.3	99	58.2	28	16.5
SubTotal	1073	250	23.3	617	57.5	206	19.2
MIGRANT CAMPS:							
Migrants	945	121	12.8%	585	61.9%	239	25.3%
Total	2018	371	18.4%	1202	59.6%	445	22.0%

Code: Urgency of Dental Care

0 - No care needed.

1 - Early caries, pits, fissures, by probing.

2 - Moderate caries, visible even without probe.

3 - Group caries, but with no apical infection or history of pain.

4 - Teeth decayed to the gum line, apical abscess or any other condition requiring immediate dental care.

DH 1/71

Since funding for dental care was restricted in both the school's budget and the project budget, students having urgent need (3's and 4's) were referred for dental care first. Few in the 1 and 2 categories were able to be funded for care. Migrant children receiving dental care were included in the overall total of 894 individuals receiving dental care through the project.

The complete summary of the dental health survey with supportive and comparative data is included in the appendix.

NURSING SERVICES

The migrant nurse plays an important role in the health-team approach in providing services to migrant families. Assisted by indigenous community aides, her activities include screening families for health problems and making referrals for care to appropriate resources; participating in health counseling and teaching; assisting with special screening programs; assisting upon request in health department programs that involve migrants; acting as liaison between the migrants and physicians, dentists, hospitals, and pharmacies; supervising community health aides; assuming responsibility for coordination and implementation of clinic activities; interpreting community resources and helping migrant families in utilization of these resources; assisting in coordination of community groups and agency activities relating to migrant families welfare; and keeping appropriate records to provide necessary data for program planning and reporting.

When screening migrant families, a family record is filled out (see appendix). It is made in triplicate and serves several purposes. A copy is given to the family. It includes pertinent medical information and a record of services given or of further needs, and our aim is to provide a measure of continuity of care as the family moves about. Other copies provide statistical data for reporting and service planning, a work record for the health team in follow-up care, verification of migrant status in payment of bills, basis for family services for "home-based" migrants, and data for the master migrant file. Migrant nurses and aides saw and health screened 18,694 individuals during the past year. They made 12,267 household visits providing services to 13,134 persons. Following are tables indicating the ethnic, sex and age composition of individuals screened.

FAMILY DATA
BY OREGON PROJECT COUNTIES, 1970

County	Total No. Families Screened	Families in Area First Time	Mexican-American	Anglo	Indian	Negro
Clackamas	186	44	75	64	36	11
Hood River	304	148	336	656	19	6
Jackson	66	20	286	107	1	1
Jefferson	108	52	100	7	0	1
Klamath	61	37	58	51	12	10
Linn	360	196	309	37	3	11
Malheur	395	65	264	5	125	1
Marion	362	179	182	174	1	3
Polk	242	126	144	77	11	10
Umatilla	121	111	33	80	2	6
Washington	431	209	254	100	0	0
Yamhill	418	307	324	93	0	1
Total	3054	1494	2365	1451	210	61
Percentage		48%	58%	35.5%	5%	1.5%

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NUMBER OF MIGRANTS SCREENED FOR HEALTH PURPOSES,
BY AGE AND SEX, IN OREGON PROJECT COUNTIES, 1970

COUNTY	OUT-MIGRANTS														IN-MIGRANTS														Total
	Under 1 Year		1-4 Years		5-14 Years		15-44 Years		45-64 Years		65+ Years		Sub-Total		Under 1 Year		1-4 Years		5-14 Years		15-44 Years		45-64 Years		65+ Years		Sub-Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
CLACKAMAS	0	1	0	1	8	2	3	4	2	0	0	0	13	8	16	8	48	52	188	159	210	203	37	33	4	9	503	464	988
HOOD RIVER	1	1	3	4	8	4	9	9	2	1	0	0	23	19	20	16	52	81	125	112	257	250	69	28	3	4	526	491	1,059
JACKSON	0	0	2	2	6	3	6	7	2	2	0	0	16	14	5	1	8	6	24	27	179	53	51	10	1	0	268	97	395
JEFFERSON	0	0	0	0	1	1	3	1	1	1	0	0	5	3	8	8	25	36	86	100	131	144	27	21	1	0	278	309	595
KLAMATH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	4	11	9	43	36	53	51	18	18	3	0	133	118	251*
LINN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	20	79	89	360	356	426	383	94	69	3	3	785	920	1,905
MALHEUR	0	3	12	17	53	56	48	53	10	6	1	0	124	135	23	17	77	85	235	182	302	316	76	64	7	3	720	667	1,646
MARION	9	10	34	59	96	88	105	137	33	18	3	0	280	312	39	63	228	181	682	623	969	771	160	118	12	5	2090	1761	4,443
POLK	2	1	4	5	35	31	36	36	11	9	1	2	89	84	17	18	73	61	208	172	262	243	63	41	2	5	625	540	1,338
UMATILLA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14	27	60	44	118	122	142	161	59	18	5	6	398	378	776
WASHINGTON	Figures Unavailable														24	22	123	115	535	453	542	499	102	51	6	2	1332	1142	2,474
YAMHILL	Figures Not Tabulated By Sex													**	See County Report For Data													**	2,824
TOTAL***	12	16	55	88	207	185	210	247	61	37	5	2	550	575	194	204	784	759	2604	2342	3473	3074	749	471	47	37	7658	6887	
																													18,694

* Does not include out-migrants
** Sub-total out-migrants: 468
Sub-total in-migrants: 2356
*** Totals in age categories do not include Yamhill County data

Outreach activities of nurses and aides provide not only referral to medical services but provide follow-up on prescribed care. Working under standing orders of the local health officer they may also treat such conditions as minor skin infections, impetigo, and pediculosis. In addition to routine orders, they may carry out special orders in control of communicable diseases such as in the case of one county's epidemic of streptococcal sore throat during the past summer.

If the local project area has a migrant school or day care center, the nurse makes regular visits to these facilities to provide health consultation to the staff and to follow through on medical or dental referrals made on the children. Information on nurse and aide services by type is shown on the following tables.

County	FIELD NURSING					CONTINUITY OF CARE						
						REFERRALS MADE						
						MEDICAL CARE					DENTAL CARE	
							IN AREA		OUT OF AREA			
	Visits to Households	Households Served	Persons Served	Visits to Schools - Day Care Centers	Persons Served	Total Made	Made	Completed	Made	Completed	Made	Completed
Clackamas	738	186	988	0	0	234	216	172	18	3	41	30
Hood River	803	304	1059	199	342	620	573	539	47	26	72	72
Jackson	450	100	395	0	0	58	57	50	1	1	6	1
Jefferson	172	108	595	17	57	77	77	77	0	0	12	4
Klamath	390	61	75	2	2	143	107	107	36	36	34	31
Linn	1400	145	775	0	0	446	415	346	31	1	50	50
Malheur	2740	548	3288	108	620	2917	2887	2743	30	26	508	383
Marion	682	362	1932	23	216	377	333	311	44	23	191	142
Polk	931	242	1338	22	150	148	146	146	2	2	46	42
Umatilla	399	117	215	100	200	170	169	155	1	-	-	-
Washington	1716	427	2474	61	190	877	866	788	11	-	137	43
Yamhill	1946	-	-	-	-	29	0	0	29	6	133	100
Total	12,267	2600	13,134	532	1777	6096	5846	5434	250	132	1230	893

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NURSING AND AIDE SERVICES BY TYPE IN OREGON PROJECT COUNTIES, 1970 (con't)

CONTINUITY OF CARE							
	REFERRALS RECEIVED				USE OF HEALTH RECORD		
	MEDICAL - DENTAL CARE FROM OUT OF AREA		FOLLOW-UPS TO MEDICAL OUTPATIENTS WITHOUT REFERRALS	NUMBER GIVEN PRE-DISCHARGE PLANNING AND Post HOSPITAL SERVICES			
County	Received	Completed			No. Requested To Present Record	No. Presenting Record	No. Given Record
Clackamas	2	1	7	5	780	102	726
Hood River	9	6	13	48	1059	84	311
Jackson	0	0	1	2	275	4	99
Jefferson	-	-	-	-	108	49	34
Klamath	-	-	5	2	61	1	55
Linn	0	0	-	-	-	13	0
Malheur	3	1	-	90	270	67	200
Marion	59	50	15	68	798	47	703
Polk	1	1	28	11	1338	234	438
Umatilla	0	0	5	23	425	20	60
Washington	3	2	6	2	2474	22	427
Yamhill	0	0	0	6	-	-	-
Total	77	61	80	247	7588	643	3053

An important aspect of the migrant health program is health education by all members of the staff. Preventive services are more desirable than curative services; therefore, increasing emphasis is placed on health education. Working directly with migrant families in their homes enables the staff to establish a good working rapport with them and to provide health counseling. Specific information regarding health education is included later in this report.

To help the migrant maintain an optimum of good health and effectiveness of treatment it is often essential to provide some means of continuity of care. The present system of intra- and interstate referral, while not completely effective, seems to be the most workable means yet devised and has greatly facilitated care for many individuals. It has been observed that project nurses are able to meet health needs more effectively because of the possibility of providing continuity of care. This results in more effort being directed toward conditions requiring long term care. In spite of the problems in sending referrals and obtaining requested services, it appears progress is being made in providing care on a continuing basis.

It has been the intent to have all referrals go through the state office, though it has been common practice to have intrastate referrals sent directly from one county to another county, with copies to the state office. Many times the referrals have been by telephone. Therefore, it has not always been possible to have complete records in the central office on all referrals. The following tables show data on number of individuals and types of conditions referred on both intra and interstate referrals. The largest number of referrals involved tuberculosis followup. There were also a number of referrals for venereal disease followup. Most of these were a result of venereal disease screening done at a migrant clinic, the results frequently were obtained after the migrant had left the area. Since many of the referrals were sent to other states at the end of the migrant season, it was not

possible to receive replies before the report period ended; and last year at least 20 replies were received after the reporting period. It is expected that there will be at least that many this year, if not more. Many of the referrals are for information only, so it is not essential for a reply to be sent.

OREGON INTERSTATE REFERRALS

December 1, 1969 - November 30, 1970

	Referrals To Other States			Referral From Other States		
	Referred To	Responses From	Completed	Referrals From	Response To	Completed*
Arizona	15	6	3	2	2	2
Arkansas	4	-	-	-	-	-
California	34	13	10	4	3	3
Idaho	8	3	2	1	1	-
Indiana	2	2	2	1	1	1
Missouri	2	1	-	-	-	-
New Mexico	3	3	-	-	-	-
Oklahoma	1	-	-	-	-	-
South Dakota	1	1	1	-	-	-
Texas	72	21	19	9	9	6
Utah	-	-	-	1	1	1
Washington	14	9	3	10	10	4
Totals	156	59	40	28	27	17

*Indicates that the desired information was obtained or the person referred was located and plans were made for continuity of care. Excludes those who could not be located or when the information desired was unknown.

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INTERSTATE AND INTRASTATE REFERRALS

December 1, 1969 - November 30, 1970

DISEASE CONDITIONS REFERRED - AS CLASSIFIED BY CATEGORIES (ICD)

I. INFECTIVE AND PARASITIC DISEASE. 94
- Tuberculosis - 73
- Bacterial, viral, fungal infections - 5
- Venereal disease - 15
- Helminthiasis - 1

II. NEOPLASMS. 4
- Malignant neoplasms - 2
- Benign neoplasms - 2

III. ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES. 11
- Disease of thyroid - 2
- Diabetes Mellitus - 9

IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS 1
- Anemia - 1

V. MENTAL DISORDERS 12
- Psychoses and neuroses - 10
- Mental retardation - 2

VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS. 37
- Epilepsy - 4
- Diseases and/or conditions of the eye - 19
- Diseases and/or conditions of the ear - 14

VII. DISEASES OF THE CIRCULATORY SYSTEM 4
- Heart disease - 2
- Varicose veins - 2

VIII. DISEASES OF THE RESPIRATORY SYSTEM 4
- Tonsillitis - 3
- Atelectasis - 1

IX. DISEASES OF THE DIGESTIVE SYSTEM 10
- Dental - 5
- Duodenal Ulcer - 1
- Hernia - 4

X. DISEASES OF THE GENITOURINARY SYSTEM 6
- Diseases of urinary system - 3
- Diseases of uterus and other female genital organs - 3

XI. COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM 5
- Abortions - 4
- Rubella in 1st trimester - 1

XII. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE 2

XIII. DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE 5
- Osteomyelitis - 1
- Disease of joint - 3
- Back disorder, unspecified - 1

XIV. CONGENITAL ANOMALIES 8

XV. CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY. 1
- Prematurity - 1

XVI. SYMPTOMS AND ILL-DEFINED CONDITIONS. 10

XVII. ACCIDENTS, POISONINGS, AND VIOLENCE. 4
- Eye injury - 2
- Knee injury - 2

SUPPLEMENTARY. 31
- Pre-natal or post-natal care - 10
- Family planning - 4
- Special tests (Pap & PKU) - 5
- Medical information - 6
- Immunizations - 5
- Other (child neglect) - 1

Total referrals from all project counties. 249
(Total individuals referred - 235)

I. INFECTIVE AND PARASITIC DISEASE. 94
Tuberculosis - 73
Bacterial, viral, fungal infections - 5
Venereal disease - 15
Helminthiasis - 1

II. NEOPLASMS. 4
Malignant neoplasms - 2
Benign neoplasms - 2

III. ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES. 11
Disease of thyroid - 2
Diabetes Mellitus - 9

IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS 1
Anemia - 1

V. MENTAL DISORDERS 12
Psychoses and neuroses - 10
Mental retardation - 2

VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS. 37
Epilepsy - 4
Diseases and/or conditions of the eye - 19
Diseases and/or conditions of the ear - 14

VII. DISEASES OF THE CIRCULATORY SYSTEM 4
Heart disease - 2
Varicose veins - 2

VIII. DISEASES OF THE RESPIRATORY SYSTEM 4
Tonsillitis - 3
Atelectasis - 1

IX. DISEASES OF THE DIGESTIVE SYSTEM 10
Dental - 5
Duodenal Ulcer - 1
Hernia - 4

X. DISEASES OF THE GENITOURINARY SYSTEM 6
Diseases of urinary system - 3
Diseases of uterus and other female genital organs - 3

XI. COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM 5
Abortions - 4
Rubella in 1st trimester - 1

XII. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE 2

XIII. DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE 5
Osteomyelitis - 1
Disease of joint - 3
Back disorder, unspecified - 1

XIV. CONGENITAL ANOMALIES 8

XV. CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY. 1
Prematurity - 1

XVI. SYMPTOMS AND ILL-DEFINED CONDITIONS. 10

XVII. ACCIDENTS, POISONINGS, AND VIOLENCE. 4
Eye injury - 2
Knee injury - 2

SUPPLEMENTARY. 31
Pre-natal or post-natal care - 10
Family planning - 4
Special tests (Pap & PKU) - 5
Medical information - 6
Immunizations - 5
Other (child neglect) - 1

Total referrals from all project counties. 249
(Total individuals referred - 235)

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The statistical reports do not fully show all the kinds of activities and time spent by the nurse with respect to her involvement in community activities. There are, in any community having migrants, many official and voluntary groups interested in the migrants welfare. Church groups, growers associations, organized consumer groups, service organizations, state and local programs and agencies offer a variety of services to the migrants. Leadership in coordination of group efforts has usually been assumed by the project nurse. In order to help the migrant utilize available services she must be knowledgeable of the scope of services offered. Establishing personal working rapport with members of these groups or agencies usually attains better results.

In line with the Federal Government's general concern that persons representative of the population to be served have an opportunity to participate in planning and implementation of programs, the Oregon Migrant Health Project has encouraged, as a first step, the establishment of local advisory committees. Often it is the local project nurse who is delegated the responsibility of planning and organizing such a committee. She serves as the catalyst to get such a committee functioning. She also serves as a liaison between the committee and the health department. Consumer involvement in the migrant project is included in a later discussion.

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SANITATION SERVICES

The results of this past season's efforts have shown that 1970 was a year of substantial progress toward bringing the living conditions in the farm labor camps in this state up to an acceptable level. It was also a time of confusion and restlessness for government, the agricultural community, and the migrant workers; primarily brought about by various militant factions claiming to represent the seasonal farm work force. Volunteer workers, civil servants, and others who have worked for years to raise the social standards of the migrant workers are now dismayed, and disdain to work or participate in programs with these militant groups.

It seems more than appropriate to comment upon the activities going on both within and outside of the state that affect the progress of the program. It has been indicated in past reports, in accordance with wishes of the Public Health Service, that financial support for improving the environmental aspect of the migrant health program should be reduced. The savings from this action were to be diverted to the medical care components. Over the past two years this has been accomplished, and at the present time only 16% of the total project funds go into this aspect of the program. This 16% includes the employment of sanitarians, aides, and their travel expenses. This support is presently going to 10 of the 12 project areas. We now understand that the Public Health Service is desirous of supporting only viable and innovative environmental programs rather than the traditional programs. Not surprisingly, nothing is mentioned about the effectiveness of the programs to be supported, and little is indicated concerning program directions to be followed. The responsibility for assuring farm workers and their families a healthy place to live and work has been and still remains a state responsibility. If it is the intent of the Public Health Service to continue this reduction of program support, it would seem that a stated policy indicating a scheduled rate of program reduction or a deadline when this support will cease should be specified.

As was indicated in the last annual report, proposed changes in the Rules and Regulations of the State Board of Health were prepared. Prior to submitting these regulation changes for adoption by the State Board of Health, ten meetings were held throughout the state. Representatives from agriculture and farm workers were contacted to obtain their comments and recommendations. This being accomplished, the proposals went to public hearing, and were subsequently adopted by the State Board of Health in February, 1970. It was unfortunate that the rules were adopted as late as February, because many farmers felt they were given insufficient time to comply with the new standards. The normal problems of disseminating information were at least partially alleviated by the assistance of the Cooperative Agricultural Extension, the Oregon State Employment Service, and the State Bureau of Labor. These agencies assisted the State Board of Health and the local health departments to "spread the word" concerning the new standards in all areas of the state.

Subsequent to the adoption of the new regulations, a meeting of all sanitarians involved in the farm labor health program was held at the State Board of Health in Portland. The new standards were reviewed, and various problems, including the implementation of the regulations, were discussed. It was generally accepted that there would be no grace period for actuating the new standards.

Because of concurrent jurisdiction by the State Bureau of Labor and the Employment service with the local health departments, in the enforcement of the farm labor camp standards, a meeting was called by the State Health Officer. The administrator of the Employment Service, the State Labor Commissioner, a county Health Officer, and their respective staffs met to define the roles and responsibilities to be assumed by each agency, especially by the Bureau of Labor and the Employment Service. It was decided at this meeting that the Employment Service would use the services of the local health departments and the State Board of Health to certify farm

labor camps for labor placement purposes, both inter and intra-state. The Bureau of Labor would participate in the enforcement aspect of the program; inspecting farm labor camps, and if necessary closing facilities that were determined to be a serious health hazard.

These pre-season activities set the stage for what was to come during the remainder of the year. It had been now definitely established that the Board of Health would push for strict enforcement of these new standards. For the first two months, the Board of Health's Occupational Health sanitation staff assumed the responsibility for implementing the Polk and Linn County programs. This involved the pre-season inspections and explaining to the camp operators the new standards and what must be accomplished before they could operate. Just before occupancy, the large housing-authority-operated farm labor camp in Yamhill County suffered a fire in their central service building. This fire destroyed all of the men's showers, the majority of the men's toilet facilities, and the laundry facilities. The Board of Health was asked to assist in the evaluation of the camp, and to recommend a course of action for the local health department. The Board of Health recommended that the camp not be allowed to open unless immediate improvements were made to the central service facilities. These improvements were subsequently made and the majority of the lost facilities restored. Only a portion of the camp was permitted to open this year. The majority of time during the rest of the summer was spent going from county to county trying to maintain a continuity of local inspections and enforcement.

In Marion County a serious dispute arose among the Local Farm Bureau Organization, the local health department, the Board of Health, and the Bureau of Labor. The local farm bureau took exception to the action taken by the above agencies relative to the tentative closure of several farm labor camps, due to the condition of the camps and the lack of necessary facilities. This problem was resolved when the Marion County Growers received advice from their attorney that they must either comply with the standards or close their camps. The majority of growers brought their camps into compliance. In Clackamas County the health department representatives were refused entry into one camp. Sufficient information was obtained concerning this establishment to obtain a search warrant to gain entry. This camp was subsequently closed but the case ended in court with a conviction of the camp owner.

This was the year for court action. The concerted enforcement effort on the part of local health departments resulted in a variety of court cases over camp closures. In all cases, except one in Hood River County, the camp operators were convicted and the laws and regulations upheld. In Hood River County, access to approximately six camps was denied the health department by two growers. The opinions of the District Attorney and the Attorney General were that if access was denied, there was no immediate recourse to obtain entry.

As a result of this particular situation and the potential problem it could create, a bill is being submitted to the legislature which would permit the issuance of entry warrants where access for the purposes of health inspection is denied. It is hoped that this Bill, if passed, will resolve these isolated, but troublesome, situations. This is the only legislation relating to farm labor housing being presented by the Oregon State Board of Health. However, the State Comprehensive Health Planning Committee recommends that legislation be introduced which would: 1) Require a minimum of 60 square feet per person for the living, sleeping, and eating units; 2) Require electric lighting in the cooking, sleeping, bathing, and toilet areas of the camp; 3) Require mechanical refrigeration for food storage; 4) Require that housing used for families with one or more children over six years of age have a partitioned area for the husband and wife; 5) Require the provision

of drinking water in the fields; and 6) Require hand washing or cleaning facilities in places of employment. Legislation which would do this and more is being introduced at the 1971 session of the legislature by a coalition of farm labor oriented groups.

As for the accomplishments of this past season, the following statement of conditions indicates the effect of the new standards on farm labor camps for the entire State:

1. The number of camps that met standards prior to occupancy 506
2. The number of camps that failed to meet standards prior to occupancy 315

of these:

A. The number of camps that were brought into compliance prior to occupancy 86
B. The number of camps that were opened and subsequently closed because of their failure to meet minimum standards 16
C. The number of camps that never opened because of their inability to meet standards 48
D. The number of camps that failed to meet standards, but were permitted to open and remain open 165

3. The number of camps that were closed because they failed to maintain their camp and facilities 18
4. The number of camps in the State that were never inspected (there is no knowledge as to their condition) 42

Also included is a summary table of the activities and accomplishments of the local projects and the Oregon State Bureau of Labor. These are for the most part self-explanatory and are generally covered in individual county reports.

The overall evaluation of this year's activities reveals that the farm labor health program, with the financial assistance of the migrant health project, had its most productive year since the program was organized in 1959.

The 1971 plans are for the program emphasis and activities to continue much the same as they were this year. Farm labor camp surveys will begin again, using the new standards, so as to maintain better program surveillance throughout the State. Initially the program emphasis will be directed to those 165 farm labor camps that failed to meet the new regulations this year, and to those 42 camps that were never inspected. The emphasis then will be on camp maintenance and hopefully, there will be sufficient time and staff available to pursue the field sanitation problems as yet unsolved.

TABLE A

SURVEY OF HOUSING ACCOMMODATIONS

	CAMPS				OTHER LOCATIONS			
County	Number	Maximum Capacity	Peak Occupancy	Units	Number	Maximum Capacity	Peak Occupancy	Units
Clackamas	42	1,304	1,304	281	18	103	103	0
Hood River	347	5,202	5,193	2,862	19	0	0	0
Jackson	33	444	444	0	12	0	0	0
Klamath	1	500	395	71	0	0	0	0
Linn	13	1,146	1,146	270	0	0	0	0
Malheur	27	1,245	1,845	320	293	2,500	2,344	293
Marion	134	8,515	8,500	1,703	0	0	0	0
Polk	31	1,370	1,370	373	0	0	0	0
Umatilla	6	609	609	140	6	56	56	7
Washington	35	2,455	2,455	483	0	0	0	0
Yamhill	22	2,765	2,765	351	7	226	226	37
Total	691	25,555	26,026	6,854	355	2,885	2,729	337

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INSPECTION OF LIVING ENVIRONMENT OF MIGRANTS

NUMBER OF LOCATIONS INSPECTED

COUNTIES	Water		Sewage		Garbage & Refuse		Housing		Camp Maintenance		Toilet Facilities		Insects & Rodents		Lavatory & Laundry	
	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other
CLACKAMAS	42		42		42		42		42*				42			
HOOD RIVER	307		307		307		307		307		307		307		307	
JACKSON	28		9		35		35		35		35		35		35	
KLAMATH	1		1		1		1		1		1		1		1	
LINN	13		13		13		13		13		13		13		13	
MALHEUR	27	1	27	1	27	1	27	1	27	1	27	1	27	1	27	1 1**
MARION	134		134		134		134		134		134		134		134	
POLK	31		31		31		31		31		31		31		31	
UMATILLA	2	2	3	6	6	3	6	3	6	3	6	3	6	3	6	3
WASHINGTON	35		35		35		35		35		35		35		35	
YAMHILL	22	7	22	7	22	7	22	7	22	7	22	7	22	7	22	7
TOTALS	642	10	624	14	653	11	653	11	653	11	611	11	653	11	611	12

* Safety
** Food Handling

TOTAL NUMBER OF INSPECTIONS

COUNTIES	Water		Sewage		Garbage & Refuse		Housing		Camp Maintenance		Toilet Facilities		Insects & Rodents		Lavatory & Laundry	
	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other
CLACKAMAS	53		90		90		90		90*				90			
HOOD RIVER	384		384		384		384		384		384		384		384	
JACKSON	64		44		58		170		170		170		170		170	
KLAMATH	1		1		1		1		1		1		1		1	
LINN	13		13		42		13		42		42		14		42	
MALHEUR	50	1	50	1	50	1	50	1	50	1	50	1	50	1	50	1
MARION	53		400		400		400		400							
POLK	96		96		96		96		96		96		96		96	
UMATILLA	2	9	3	6	24	15	24	15	24	12	24	12	24	15	24	12
WASHINGTON	227		7		725		984		962		780		38		164	
YAMHILL	33		68	4	67	4	44	4	67	4	69	4	66	4	69	4
TOTALS	976	10	1156	11	1937	20	2256	20	2286	17	2016	17	1008	20	1350	17

* Safety

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NUMBER OF DEFECTS FOUND

COUNTIES	Water		Sewage		Garbage & Refuse		Housing		Camp Maintenance		Toilet Facilities		Insects & Rodents		Lavatory & Laundry	
	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other
CLACKAMAS	11		63		34		62		32*				17			
HOOD RIVER	4		42		147		209		86		102					
JACKSON	10				7				12		15		25		10	
KLAMATH			2													
LINN			1		12		1		3		16		2		2	
MALHEUR	3		3		4	1	6	1	5	1	9	1	2	1	16	1
MARION	16		125		240		150		220		120		40		100	
POLK	10		15		27		23		25		56		16		26	
UMATILLA	1	1			3	9	1		2	9		1				
WASHINGTON	30		4		116		75		69		121				16	
YAMHILL	6	3	26	1	25	3	23	2	11	2	39	3	4		21	3
TOTALS	91	4	281	1	615	13	550	3	465	12	478	5	106	1	191	4

* Safety

NUMBER OF CORRECTIONS MADE

	Water		Sewage		Garbage & Refuse		Housing		Camp Maintenance		Toilet Facilities		Insects & Rodents		Lavatory & Laundry	
	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other	Camp	Other
CLACKAMAS	10		53		27		45		30*				15			
HOOD RIVER	2		20		105		134		67		61					
JACKSON	8				7				12		14		24		8	
KLAMATH																
LINN			1		10		1		1		13		1		1	
MALHEUR	1		3		4	1	3	1	4	1	6	1	2	1	9	1
MARION	5		100		200		90		190		100		40		95	
POLK	9		14		21		21		21		41		12		23	
UMATILLA	1	1			3	9			2	3						
WASHINGTON	18		4		64		68		67		34				15	
YAMHILL	2	1	8	1	6		7		2		12		1		9	
TOTALS	56	2	203	1	447	10	369	1	396	4	281	1	95	1	160	1

* Safety

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INSPECTION OF WORKING ENVIRONMENT OF MIGRANTS

COUNTIES	NUMBER OF LOCATIONS INSPECTED			TOTAL INSPECTIONS			NUMBER OF DEFECTS FOUND			NUMBER OF CORRECTIONS MADE		
	Water	Toilet Facilities	Other	Water	Toilet Facilities	Other	Water	Toilet Facilities	Other	Water	Toilet Facilities	Other
MALHEUR					3			1			1	
MARION					3			3			3	
UMATILLA	25	25		52	52		16	12		13	11	
WASHINGTON	120	120	112	345	999	98	124	216	22	72	145	16
YAMHILL	381	349	—	396	316	—	56	121	—	6	24	—
TOTAL	526	494	112	793	1373	98	196	353	22	91	184	16

BUREAU OF LABOR ACTIVITIES 1970

COUNTY	FARM LABOR CAMPS		FARM LABOR FIELDS			
	INSPECTIONS	VIOLATIONS	INSPECTIONS	VIOLATIONS		
				WATER	TOILET FACILITIES	OTHER
BENTON			7			
CLACKAMAS	11	4	21		27	
DESCHUTES			3			
JACKSON			15		20	
JEFFERSON			6		3	
KLAMATH	3	8	3			
LANE			31	3	55	2
LINN	27	13	88		34	
MALHEUR			28	2	22	
MARION	70	137	295	3	103	
MULTNOMAH	7	0	31	4	46	
POLK	4	13	34	1	26	
UMATILLA			1			
WASCO	68	116	44		6	
WASHINGTON	22	21	27	4	44	
YAMHILL	4	4	64	1	21	—
TOTAL	216	316	698	18	407	2

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HEALTH EDUCATION SERVICES

The following narrative describes activity areas in health education and the efforts being made to obtain project objectives. Please refer to the 1969 Oregon Migrant Health Project Annual Report, pp. 30-31, for a listing of problems as seen by the migrant, staff, and others. Continued staff attention is required to solve the listed problems.

STAFFING: Provision of health education services is the responsibility of one full-time public health education consultant, working with the State project, serving 12 county projects. Actual implementation of the health education process (which for our purposes emphasizes community organization and involvement of the individual in solving his own health problems) depends on staff nurses, community health aides and sanitarians of the local projects. In order to help local staffs accomplish project objectives through the health education process, they are provided: 1) consultation for planning and implementing health education services; 2) in-service training; and 3) direct services.

CONSUMER INVOLVEMENT: The objective in consumer involvement is to develop a PARTNERSHIP between the service consumers and service providers, recognizing and utilizing the talents of both in the provision of quality migrant and rural health services. Consumer involvement appears to be the giant step linking traditional treatment efforts with innovative preventive measures.

The primary method being used to obtain organized consumer involvement is the establishment of advisory committees composed partially of consumer representatives. The increase in numbers of local projects having organized advisory committees indicates a change in administrative thinking: that consumer involvement is a valid public health method. (The success and failure of the advisory committees relate to the influencing factors of staff time, understanding, and personal commitment to the "self help" concept.) The short term stay of consumers in an area limits their ability to participate as committee members. Therefore, settled-out migrants and groups partially representing migrants have been tapped for participation as committee members. The major barrier to obtaining good migrant representation on a committee is the variety of rival factions existent among the Mexican-American population. For instance, the Chicano group is not recognized as a representative body by all Mexican-Americans in Oregon. Yet, the Chicano group is more organized than are the remainder of the Mexican-Americans, and therefore more visible and audible.

Plans to organize an advisory committee for the State migrant health project were initiated in 1969, received the approval of the State Health Officer, then failed to materialize due to USPHS cuts in the 1970-71 Oregon migrant health budget. Contingent upon funds, plans are to establish such a committee, composed of one representative from each of the local project advisory committees, equalling 12 members.

We hope to work through Comprehensive Health Planning in obtaining consumer involvement. Comprehensive Health Planning in Oregon continues to be in an organizational period. The State Comprehensive Health Planning Council, of 19 members, includes one former migrant. Two Regional Comprehensive Health Planning Councils are organized in the State, one of which covers a geographical area with migrant population. The health plan developed by the State Comprehensive Health Planning staff includes the migrant health project. This plan is to be presented to the Governor for his subsequent approval or disapproval. It is the intention of the State project staff to promote the membership of migrants or migrant representatives on local and regional Comprehensive Health Planning Councils, with these groups eventually providing advice to local migrant health projects. In order to maintain organized migrant involvement in the project, it will be necessary

to recommend sub-committees to the Councils which would have the responsibility of reviewing the local migrant health projects. This method would alleviate the problems of establishing numerous committees in each area, each having separate advisory functions; such as the Home Health Agency advisory committee, the Family Planning advisory committee, the Dental Health advisory committee, the Migrant Health advisory committee. . . . .

OUTREACH SERVICES: Outreach services, provided through the migrant health project via community health aides and project nurses, have made a definite impact on the migrants' utilization of local health services and the special migrant health services. Without such "outreach" the local health services would remain inaccessible and possibly unacceptable to the migrant population. Efforts are being made to establish "outreach" as a permanent service in local health departments. (See details in the following discussion on community health aides.)

The Mexican-American migrants have closely identified with the community health aides, who are former migrants, and with nurses and sanitarians who have Spanish speaking ability. Much more health information has been provided and behavior change influenced due to the acceptability of the outreach service.

Individual counseling has been the primary method of providing health information in the camps via project nurses and community health aides. In 1970, 3 project areas were involved in group sessions held within camps. The effectiveness of these attempts is directly related to the degree of involvement of the migrant in the sessions. Those sessions which had a lecture format were least effective. Those which used a demonstration-practice format proved more valuable in that the learner actively participated. The group sessions concerned: 1) use of abundant foods; 2) first aid; and 3) toothbrushing. The limiting factors concerning group sessions were the lack of staff time and group work skills. Five of the twelve projects have developed and used community service pamphlets. The value of this type of health information is illustrated by one local Migrant Ministry group reporting an overwhelming patronage of their clothing supply service the evening following the project nurse's contact with the migrants in surrounding farm labor camps. At this contact, the nurse provided the service pamphlet to families new in the area and discussed the type of help available in the community. Previous to the use of the pamphlet, the clothing service experienced moderate usage.

COMMUNITY HEALTH AIDES: Training and employment of community health aides by local projects has reached its limit, under present local administrative and Federal funding conditions. In 1970 there was an increase in the number of aides employed year 'round (from 1 to 3), based on year 'round migrant population needs in 3 counties. Efforts to obtain joint funding for aide positions allowing full-time employment in local health departments have been fruitless. However, some gains have been made:

a. The County Merit System has adopted an aide classification (Community Health Worker), based on a general job description prepared by the State project for aides working with local migrant health projects. This classification provides an entry level position into health careers for persons with an eighth grade education and the ability to read and write (English). At this point, the migrant health projects are the only county level programs utilizing this category;
b. a request has been made by the Oregon Migrant Health Project that the State Board of Health officially support the career ladder concept for auxiliary personnel, thus enabling staff to promote a Board of Health policy rather than a personal idea;

c. the State Department of Personnel has received Federal funds to develop mental health aide slots on a career ladder basis in State institutions. Bargaining is ongoing to divert a few of the slots to public health for demonstration purposes, using a migrant health project aide position for development into an aide position in the general program of a local health department;
d. the State OEO office is strongly encouraging local Community Action Programs to develop New Careers Programs. State OEO has requested the help of the Oregon Migrant Project staff to interest local health departments in career development for the disadvantaged. Presently, efforts are being made in one county demonstration area in which a local migrant health project is located;
e. one county health department is planning to use STEP students in aide capacities and is considering involvement of this type aide with their migrant health project as well as the general health department program;
f. the Oregon Department of Sanitarians (the State Registration Board) agreed on November 25, 1969, that the PUBLIC HEALTH AIDE could be utilized under the direct supervision of a Registered Sanitarian. They generally conceded that the aide could be TRAINED to observe in all areas of environmental sanitation and report findings to the Registered Sanitarian. The Registered Sanitarian would then either follow up on reported information or take action based upon the information. The aide should not be involved in ENFORCEMENT - DATA INTERPRETATION - or any other area where judgment based upon professional experience or education would be required.

Community health aides are becoming more valuable to the local migrant health projects as evidenced by 3 local budget requests for additional aide positions or more aide time, rather than more positions for professionals. Improvements in the aide program call for better aide supervision and training.

TRAINING: Changes are planned in the content of pre-season and in-service orientation and training for community health aides, to better equip them to handle priority health problems of the migrants. In the past, the aides have been provided general pre-season orientation and in-service training at statewide and regional meetings, with follow-up specific training being provided on the local project level. Due to short term employment and lack of focus on specific problems, the aides have been unable to function effectively in health education. Therefore, training will be geared in 1971 to equip the aides to help the migrant families:

1) understand and practice treatment of the common cold;
2) practice skin care through thorough washing with soap;
3) recognize need for early and regular prenatal care to prevent problems during pregnancy;
4) increase the dietary intake of Vitamins A and C (the 1969 Polk County nutritional survey of migrant children revealed Vitamin A and C deficiencies);
5) better utilize abundant foods within their own diet;
6) practice dental hygiene and understand the reason why;
7) avoid accidents in the home and camp by focusing on camp maintenance (disposal of broken glass, abandoned refrigerators. . . . .) .

The number of in-service training and orientation sessions during 1970 were increased. Spring meetings were held for:

1) supervisory nurses of local health departments, to re-acquaint them with project goals and to discuss new policies and procedures (the "in-basket" technique was used effectively);

2) supervisory and project sanitarians of local health departments, to acquaint them with the revised regulations (adopted by the State Board of Health in February 1970) for camp and field sanitation, and to explore the use of aides for sanitation inspections;
3) for project staff, to orient them to priorities in the migrant health project, to familiarize them with their general job responsibilities, and to equip them with some educational techniques.

A mid-summer meeting, planned by local project staffs, was held for six of the project areas, to present mid-season problems and discuss solutions. The meeting emphasized "team work."

In Fall 1970, a two day workshop was scheduled for all project and administrative staff of the 12 local health departments. A planning committee representing seven local projects designed the workshop to give special attention to:
a. legal rights of migrants, growers, and project staff;
b. agency cooperation and coordination to avoid duplication of services;
c. solutions to camp safety and maintenance;
d. consumer involvement; and
e. nursing and sanitation problems.

"The Public Health Worker As A Change Agent", a 5 day USPHS/CDC course, is scheduled for the week of October 18, 1971. The course will take the place of the annual meeting of the Oregon project staff. Course participants, after training, will be better equipped to involve migrants in solving their own problems, rather than the public health worker's solving the problems with little or no involvement of the migrant. The latter leads to dependency and does not foster behavior change: the major reasons why public health problems persist.

COORDINATION AND COOPERATION: The provision of migrant health services requires the involvement of numerous official and voluntary agencies as well as local service groups and individuals. When reviewing the types and amount of services provided, it is quite evident that the Oregon Migrant Health Project could not, alone, finance nor provide such. For this reason, much project staff effort is put into soliciting help from others and attempting to integrate migrant health services into a permanent health service system. To date, health services for migrants remain dependent basically upon Federal migrant health funds. For example:

> "Your 1970 hospital component request will be cut 20%, 1971's 50%, and in 1972 hospitalization will not be a budgeted item. The intention of the phase-out is to make maximum use of other resources, such as Title 19 funds. In the State of Oregon, Title 19 funds are an available resource to the migrant farm worker and his family ONLY if eligibility requirements are met for the Public Welfare Categories of Aid to Dependent Children, Old Age Assistance, Aid to the Blind, or Aid to Disabled. The migrant must be a welfare categorical recipient prior to hospitalization, as funds are not retroactive. The encouragement of the Public Health Service to affect reciprocal payment arrangements between Oregon's Title 19 program and the Title 19 programs in other states, to cover hospitalization costs of the transient farm worker families, will be a difficult task. For example, the State of Texas (a home base for the majority of the migrant farm workers who harvest crops in Oregon) has announced a 20% cut in Title 19 funds (effective April 1, 1970); a cut without which the State of Texas would face a $42 million deficit within 17 months. . .Thus a reciprocal payment arrangement with the State of Texas is not realistic. The lack of financial resources places an unbearable burden on low-income families whose chronic health conditions increase as the incomes decrease. A POVERTY - POOR HEALTH CYCLE IS CREATED WHICH CANNOT BE BROKEN WITHOUT FINANCIAL RESOURCES." 1

1. MIGRANT HEALTH NEWS, Oregon State Board of Health, vol. II, No. 4-5 April-May 1970.

The types of cooperation and support received from other groups are primarily 1) planning and consultation, 2) finances, and 3) services. The following is a list of agencies and groups which have been particularly helpful in the provision of services to migrant agricultural workers and their families:

Department of Education
Department of Welfare
Employment Service
Bureau of Labor
Department of Motor Vehicles
Department of Vocational Rehabilitation
Tuberculosis and Health Association
State Tuberculosis and Mental Hospitals
Shriners Hospital
Providence Hospital
Emanuel Hospital
University of Oregon Medical School
University of Oregon Dental School
Council of Churches
Devers Eye Clinic
Academy of General Practice
Local Service Groups
Local Health Departments
State Board of Health
    Local Health Services
    Epidemiology
    Maternal and Child Health
    Dental Health
    Tuberculosis Control
    Venereal Disease

In some instances, funds have been pooled to improve and/or expand services, as project funds cannot begin to meet all the health needs of migrants. A majority of project funds, at present, are allocated for payment of medical care. Prevention, a necessary public health method, is inadequately funded; it takes a second seat to the priority - curative services. Ways to expand preventive efforts (without additional funds) have not been fully explored; i.e., use of volunteers and expanded use of community health aides. Plans for the 1971 season include utilizing the talents of college health students for "in-camp" health instruction, and of a local dental health advisory committee for toothbrushing instruction in the migrant summer schools and farm labor camps.

The value of migrant health advisory committees in bringing about local coordination and cooperation is being realized. For example, the supervisory nurse in one health department spent most of the 1970 season making personal pleas to local service groups to purchase eye glasses for migrants. It is the nurse's feeling that involvement of these same service groups on the advisory committee will bring them closer to the need and make the local cooperative effort less time consuming, yet more effective.

See "Proposed Changes" section for further information.

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NUTRITION

GOALS - LONG AND SHORT TERM

When I began my new job in April, I was asked to give generalized nutrition consultation to four Oregon counties: Washington, Clackamas, Polk and Yamhill. All these counties have migrant health projects.

Short Term Goals for 1970

1. To become acquainted with the staffs of the migrant projects, especially with the nurses and the aides. To find out what nutrition problems they saw in the migrant population and what kind of help they would like to get from the nutrition consultant.

2. To learn about the general living conditions in the camps: cooking facilities, refrigeration, storage, equipment, etc.

3. To begin to learn about the foods most commonly used by migrants of different ethnic backgrounds in Oregon. To begin to learn about division of food among family members and about status foods and food beliefs, about cooking methods and shopping practices.

4. To begin to develop material to help migrant nurses and aides teach nutrition as it relates to the specific problems and food habits of Oregon migrants of different ethnic backgrounds.

5. To begin to develop methods of teaching nutrition which can be done by aides or by migrants themselves.

6. To learn about the availability of abundant foods, their acceptability and the difficulties migrants might have in obtaining them. To do the same for the supplementary foods.

7. To talk with parents and staff of the migrant school, where the nutrition survey had been conducted the previous year, and to stress vitamin A and C foods.

8. To begin to think about specific ways in which nutrition can be incorporated into the health services offered to migrants.

Long Term Goals

1. To interpret the migrant's nutrition problems to the community and to help work towards solutions. The recommendations made at the White House Conference on Food and Nutrition were :

   a. To extend the Migrant Health Act of 1962 and to extend funding to include identification and treatment of nutritional problems; for assistance in food distribution programs, for promotion of individual family and group education in nutrition, for surveillance of the nutrition problems of migrant populations and that it be organized on an interstate basis to coincide with the interstate nature of agricultural migration.

   b. That the Department of Health, Education and Welfare develop a system whereby migrant and seasonal workers can be certified as a group once annually for participation in federal food programs.

2. To work with community groups and other agencies to improve living conditions in the camps.

3. To gather as much data as possible about eating patterns and foods used by the migrants of different ethnic backgrounds and among different family members in those families. To gather nutrition-related health data. To interpret these data to staff of the migrant health projects and to others working with migrant families.

4. To develop nutrition education programs using migrants to help plan the programs and to try to obtain funds so that migrants can be paid to do the actual demonstrations and teaching.

5. To make as much food as possible available to migrant families, especially fresh fruits and vegetables and milk. To encourage the use of abundant foods, supplementary foods and/or food stamps. To try to eliminate local blocks to obtaining the food.

6. To work in training migrant health staff to teach nutrition that is pertinent to the problems (more fruits and vegetables), more milk, less pop, use of iodized salt.

The Program This Year, 1970

We attended a training meeting for migrant health nurses, aides and sanitarians. We asked them to answer two questions:

1. What do you feel is the most urgent nutrition problem of families you will be working with?

2. How do you plan to tackle the problem?

We received 32 replies and 11 of these mentioned low income as the major problem. Inadequate refrigeration in the camps was their second priority, adding more fruits and vegetables and better use of abundant foods came next. We therefore decided to stress use of abundant foods, low cost or free sources of vitamin A and C foods and an increased use of milk by encouraging the use of the donated powdered skim milk.

Washington County

We started in Washington County because the Health Educator, employed by the county health department,was interested in nutrition and because good cooperation existed between the health department and the home economics extension agent. We took a two burner kerosine stove, a folding table, abundant foods and very simple equipment. We set up shop in the center of the camp, outdoors, and demonstrated some simple one-dish meals which can be cooked from the abundant foods. We made a high vitamin C drink with the powdered skim milk and Tang or orange juice. We served raw carrots and cantaloupes to encourage the use of vitamin A and C foods. The children enjoyed our visit enormously. They helped scrape and cut up the carrots, cut up and peel the cantaloupe, open cans and stir and mix up the food. Several of the women and teenaged boys watched. When the food was cooked the children helped to dish it up and distribute it to the parents. We displayed the abundant foods and discussed them. Then we did our dishes and cleaned up. The children helped put things in the car. Later in the week the health education aide did several demonstrations by herself. She served a chocolate drink made from the powdered skim milk;and raw carrots and cantaloupe. She felt comfortable doing this and she said that the demonstration was well received.

Clackamas County

With this experience I went to the migrant nurse in Clackamas County and asked her whether they would like to try a similar demonstration. I also asked the county extension agent to participate. The health department migrant aide made all the arrangements with the growers and people in the camp. The extension home economist did the demonstration. I brought the stove and equipment and the carrots, cantaloupe and the chocolate drink. The children again swarmed around us and helped. People in the camp accepted the food well. The aide enjoyed the demonstration.

Polk County

Food demonstrations in this county were done at the request of the Health Education Consultant of the Oregon State Board of Health. The migrant health aide of Polk County Health Department made the arrangements. The nutritionist demonstrated at the first camp; the aide did the demonstration at the second camp. She also obtained the abundant foods. These were well accepted by the migrants. The children helped to prepare and distribute the food.

Talked to parents and teachers of the migrant school surveyed in 1969 by Mrs. Scott. We stressed low-cost locally available food sources of vitamins A and C and showed the film "Jennie is a Good Thing".

Yamhill County

Met with the migrant nurses to discuss the forms and method of conducting their nutrition survey.

Evaluation

A start was made in developing a simple method to encourage use of abundant foods, especially protein foods and milk, and of low cost locally available foods which supply vitamins A and C.

Communication problems were reduced by doing the demonstrations. Best results were obtained in Polk County where the aide was a Spanish-speaking former migrant.

Suggestions for Next Year

1. Budget Funds to pay migrant women in the camps to conduct demonstrations; also include pay for attending one training session.

2. Encourage state-wide certification for abundant foods and/or food stamps and simplify procedures.

3. Make abundant foods available on an emergency basis without certification.

Submitted by:

Chedwah Stein
Nutrition Consultant
Oregon State Board of Health

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PROPOSED CHANGES

FUNDING AND PROGRAM DEVELOPMENT: Increased funding is necessary to maintain the current level of medical and dental care, and to improve preventive services to migrants. An even greater amount is needed if developing health care systems in which consumers are involved in making decisions, are to be supported. It is hoped that Federal and State "multiple" funding (funds from Maternal and Child Health, Vocational Rehabilitation, Motor Vehicles, Family Planning, et. al.) would be available, to expand migrant and rural health services. In order to achieve a more equitable distribution of available funds, the Oregon Migrant Health Project is considering a formula grant allocation of funds based upon the numbers of migrants, their length of stay, and the resources accessible in an area (county).

CONSUMER INVOLVEMENT: A majority of consumer involvement in planning and implementing the Oregon Migrant Health Project is achieved through the use of county level advisory committees composed of a majority of migrants or migrant representatives. It is felt that, rather than establish separate advisory groups for local migrant health projects, the project staff should work toward expanding the area Comprehensive Health Planning Councils to include migrants, thus providing an all inclusive advisory body for the health needs of an area. Presently, the Oregon State Comprehensive Health Planning Council:

1) Reviews the Oregon Migrant Health Project
2) Solicits comments from local Comprehensive Health Planning Councils (two established to date)
3) Requests comments from all groups and agencies involved such as the Valley Migrant League - OEO, Bureau of Labor, Chicano Advisory Committee, et. al. and,
4) Makes recommendations.

One of the 19 council members is a former migrant.

Methods of achieving consumer involvement, other than through advisory groups, are more time consuming and require special skills on the part of project staff; therefore, a training course for project staff has been arranged: "The Public Health Worker As A Change Agent", to be held October 1971. This course will replace the usual annual meeting of all project staff.

OTHER EMPHASES:

1) Development of career ladders for Community Health Aides.
2) Joint funding of Community Health Aide positions, to provide year 'round employment and career opportunities.
3) Initiate a "health service identification card system" for migrants, to speed the process of getting health care in local areas.
4) "Humanize" project services by fostering an attitude change among service providers to:
   a) Respond to expressed needs of the consumer; and
   b) Help consumers develop independency in defining and solving their health problems.
5) Review project staff activities, records, and procedures, and recommend any changes deemed necessary to improve services.
6) In addition to the ongoing counseling of migrants regarding available health services, to counsel regarding when and how to use these services.

APPENDIX

PRINT - On Hard Surface

FAMILY RECORD

(Use one record for each family)

Head of Family: X. (Last Name) Jose (First Name) B. (Middle Initial) (Nick Name)

Home Address: 546 E. Wade Street (No. and Street) Mesa City (City) Arizona (State) 63454 (Zip Code)

Local Address: Cramer Camp #7 (Camp No. or Farm) Clear (County) Oregon (State) 97123 (Zip Code)

Arrival Date This Year 7/12 From Where Stockton, Calif. Next Destination Walla Walla, Wash.

Worked in Oregon Last Year Where Clear Co. Mex/Amer (x) Indian ( ) Anglo ( ) Other Specify

Social Security Number
Husb 541-65-2131 Wife 566-25-6212

Health Ins.? Yes ( ) No (x) Und ( )

Part of Crew Yes ( ) No (x) Und ( )

Crew Leader

Under Labor Contractor Yes ( ) No (x) Und ( )

Contractor

Other Identifying Information: Juan

Notify in Emergency: Box 246, Jerome, Arizona

FAMILY COMPOSITION AND MEDICAL HISTORY

NAME	Relation	Sex	Birth Date
Jose	Fa.	M	6-5-25
*Maria	Mo.	F	3-6-28
Raul	Son	M	1-2-48
Felicia	Dau.	F	4-3-52
*Roberto	Son	M	9-12-56

MEDICAL HISTORY - NURSING PLAN

Maria - Diabetic, on diabinese 250 mg/daily. 7/18/70 Seen by Dr. H. Blood sugar ordered: Report - 150 mg. No change in med. ordered. Prescription refilled.

Roberto - 7/18/70 Seen by dentist. One extraction. Needs five more fillings.

SAMPLE

Did Family Show You Their Personal Health Records? Yes (x) No ( ) Were Health Records Provided Or Updated? Yes (x) No ( )

Clear County Health Department Prepared By A. Moore, P.H.N. Date 7-16-70

Form OH-44 1/70
OSBH-MHP

MIGRANT DENTAL HEALTH SURVEY
Summer, 1970

At the time of inspection, a detailed record was made of all tooth surfaces affected by dental caries. A referral and billing form was designed (copy attached) which, if used properly would show tooth and tooth surfaces, type of service rendered in relation to the fee for each patient. This billing form would later be compared with the service inspection form to determine the level of care provided per referral. After payment has been made, the form was to be returned to the Oregon Migrant Service Center, Salem, Oregon, who would then forward these forms to the Dental Health Section of the Oregon State Board of Health. The purpose would be to ascertain the referral of care being provided in comparison to the dental inspection that was conducted in the schools. From past experiences, it was felt that more information should be known of the services being rendered in relation to the reasons for referral.

This data is in the process of being correlated. With the initial dental screening, the amount of monies expended per return of forms from Mr. Byrd's office (Migrant Service Center) shows that a total of $4,889 was billed for 76 persons. Of these persons, there were 15 persons, for which there was expended $102 for examinations in a private dentist's office, where no dental care services were provided.

For the 61 persons that received care, the average cost was $78.48 per person. There were 141 persons who were listed as 3's and 4's (in need of emergent dental care). Of 141 migrant children which were 3's and 4's, 61 (43%) were provided dental care services. It would require an additional $11,066 to provide dental care services for all children (with 3's and 4's), had they been able to obtain immediate dental care and it is estimated that approximately $43,086 for all children needing dental care would be required. Because there is a limited amount of monies available relative to the extent of the dental problem, a policy should be established that all dental care services over a certain level ($50) should have prior approval before authorization be given in encumbering funds.

Notice Table I enclosed as to the distribution of funds. There were three individuals who received care at a cost of under $50. There were nine individuals of

which the cost of care ranged from $50 - $100. For ten individuals, the cost of care ranged from $100 - $149, and eleven persons for which the cost ranged from $150 to $235. Twenty-one individuals, or 34.4% of the children, used approximately 70.8% of the amount of monies expended. The average cost for 61 children was $78.48. Forty-three percent of the 3's and 4's received care. Of those receiving care, 21 or 34.4% of the dental care cost was $3386.75 or 70.8% of funds expended.

There were 380 (141 + 239) migrants out of 1633 (688 + 945), or 23.3% classified as 3's and 4's, at a very low estimated cost of $78.48 to $29.82 needed per patient. $4,787 or 16.1% was the amount of monies expended in relationship to the total number of 3's and 4's.

An individual may have been classified as emergent (3's and 4's) for one or two teeth, of which services were expected to be provided but in turn, these individuals had other teeth restored that would have fallen under the classification of a "2", "1", or a "0". It appears that there is needed,relative to services being provided and the presentation of referrals, better communication and a policy established in order that the service to be provided falls within the reason for referral.

Even though there was a considerable amount of educational program conducted in the schools and the migrant camps, it is felt that in the future programs, more emphasis and in-service programs for the teachers and teacher's aides in the schools should be conducted.

DH 1/71
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DENTAL HEALTH SECTION
MIGRANT DENTAL HEALTH SURVEY

Summer, 1970

The objectives of the Migrant Dental Survey were twofold; it provided screening and dental education. The screening portion was designed to document the dental need of the migrant population, to establish a basis for dental care funding. In addition, a priority system regarding individual need was established to provide optimum utilization of current dental funds for treating migrants. The dental education portion of the program emphasized toothbrushing techniques and an awareness of the importance of oral hygiene.

The screening was conducted either in the Summer School Program for migrant children (on all children present) or within migrant camps on a voluntary basis. Conditions in the schools allowed a detailed examination with explorers and mouth mirrors. Here each tooth and tooth surface was examined and recorded. Also, an oral hygiene index (OHI) was determined on each child to reflect level of oral hygiene practices. At the time of the examination or during the educational program, toothbrushes were given to each child, followed by toothbrush instruction (TBI) and a self-applied fluoride paste. The facilities within the camps limited the screening to tongue depressors only.

All examinations consisted of observing each individual's general physical condition, the health state of oral tissues in relation to periodontal or systemic conditions, and observations of teeth. As previously stated, every tooth surface was recorded in the day care centers so the DMF concept could be utilized for both teeth and surfaces (this concept rates each tooth and surface as decayed, missing, or filled to indicate the incidence of dental disease. The oral hygiene index (OHI) used was based on the following:

0- No plaque or calculus on tooth
1- ⅓ or less of surface with plaque
2- 2/3 or less of surface with plaque and/or light supragingival calculus.
3- More than 2/3 of surface with plaque and/or heavy supragingival calculus.

It was recorded on six teeth, two anterior incisors and four posterior molars and the sum of the above scores on the individual teeth is added and divided by six for each person to obtain his OHI funds remained available.

DH 8/70
Rev. 1/71

Exhibit I-

MIGRANT SCHOOL SCREENING
Referral and Billing Form

School_____

Child's Name_____Age____

Tooth Number		Services Rendered	Cost
Deciduous	Permanent		

Program (Check) Title I____Headstart____Migrant_____

Date_____Signed_____
(Dentist)

INSTRUCTIONS

To Dentist: Fill out and return to Project Director as indicated below:

_____

_____

_____

To Project Director: After payment has been made, please return this form to:
Mr. Alton Byrd
Oregon Migrant Service Center
1745 13th Street, S.E.
Salem, Oregon 97302

OSBH/MH
6-5-70

TABLE I

DISTRIBUTION OF MONIES EXPENDED IN THE
MIGRANT DENTAL HEALTH SURVEY
ACCORDING TO RETURN OF BILLINGS
Summer, 1970

[illegible]		
35	$49 and under	$755.50
9	$50 - $99	$644.75
13	$100 - $149	$1275.75
5	$150 - $199	$840.00
6	$200 - $235	$1271.00
61		$4787.00

Subtotal . . . 61 persons received care. $4787.00
19 examinations @ $2-$12 each. 102.00
TOTAL . . . 73 $4889.00

TABLE 2

DISTRIBUTION OF PERSONS SCREENED
AS TO URGENCY OF DENTAL NEEDS

Migrant Dental Health Project, Summer 1970

Summer School Inspection Program:

	NUMBER	0 NO.	0 PERCENT	1-2 NO.	1-2 PERCENT	3-4 NO.	3-4 PERCENT
Migrant	688	159	20.05	448	59.55	141	20.50
Head Start	215	68	31.6	110	54.2	37	17.2
Other	190	43	25.3	99	58.2	28	16.5
Subtotal	1073	250	23.3	617	57.5	206	19.2
SUMMER CAMPS:							
Migrants	945	121	12.88	585	61.95	239	25.35
Total	2018	371	18.46	1202	59.58	445	22.06

Code: Urgency of Dental Care

0 = No care needed.

1 = Early caries, pits, fissures, by probing.

2 = Moderate caries, visible even without probe.

3 = Severe caries, but with an optimal indication as Urgency of 3rds.

4 = Teeth decayed to the gum line, apical abscess or any other conditions requiring immediate dental care.

DH 1/71

TABLE 3

DENTAL HEALTH SECTION
Dental Caries Experience - Total Number of affected
Permanent and Primary Teeth as observed in Children of Migrant Families,
Ages 2 - 15,1970

Age	No. Children	Permanent Teeth "D" Teeth	Permanent Teeth "M" Teeth	Permanent Teeth "F" Teeth	Permanent Teeth Total DMF Teeth	Primary Teeth "d" Teeth	Primary Teeth "e" Teeth	Primary Teeth "f" Teeth	Primary Teeth Total def Teeth
2	10	-	-	-	-	19	-	-	19
3	17	-	-	-	-	70	-	-	70
4	76	2	-	-	2	257	13	5	275
5	113	12	0	0	12	411	26	84	521
6	130	92	0	9	101	463	48	99	610
7	96	158	1	32	191	347	42	148	537
8	104	189	10	57	256	251	25	200	476
9	55	101	5	37	143	124	11	70	205
10	49	103	6	54	163	76	7	48	131
11	20	56	2	32	90	31	1	9	41
12	10	23	2	19	44	8	0	0	8
13	7	31	0	0	31	0	0	0	0
14	0	-	-	-	-	-	-	-	-
15	1	4	0	0	4	0	0	0	0
Total	688	771	26	240	1037	2057	173	663	2893

SH 9/10/70

TABLE 4

DENTAL HEALTH SECTION

Dental Caries Experience (Rate per child) in permanent and primary teeth of 688 children of Migrant Families, ages 2 - 15 years of age, 1970

Age	No. Children	Permanent Teeth "D" Teeth	Permanent Teeth "M" Teeth	Permanent Teeth "F" Teeth	Permanent Teeth Total DMF Teeth	Permanent Teeth T/DMF %	Primary Teeth "d" Teeth	Primary Teeth "e" Teeth	Primary Teeth "f" Teeth	Primary Teeth Total def Teeth	Primary Teeth f/def %
2	10	-	-	-	-	-	1.9	0	0	1.9	0%
3	17	-	-	-	-	-	4.12	0	0	4.12	0
4	76	.026	0	0	.026	0%	3.38	.17	.066	3.62	1.8
5	113	.11	0	0	.11	0	3.64	.23	.74	4.61	16.1
6	130	.71	0	.069	.78	8.9	3.56	.37	.76	4.69	16.2
7	96	1.65	.01	.33	1.99	16.8	3.61	.44	1.54	5.59	27.6
8	104	1.82	.10	.55	2.46	22.3	2.41	.24	1.92	4.58	42.0
9	55	1.84	.09	.67	2.60	25.9	2.25	.20	1.27	3.72	34.1
10	49	2.10	.12	1.10	3.33	33.1	1.55	.14	.98	2.67	36.6
11	20	2.80	.10	1.60	4.50	35.6	1.55	.05	.45	2.05	22.0
12	10	2.30	.20	1.9	4.4	43.2	.8	0	0	.8	0
13	7	4.43	0	0	4.43	0	0	0	0	0	0
14	-	-	-	-	-	-	-	-	-	-	-
15	1	4	0	0	4	0	0	0	0	0	0
Total	688	1.12	.04	.33	1.51	25.18	2.99	.25	.96	4.20	22.94

SH 9/10/70

TABLE 5

DENTAL HEALTH SECTION

Dental Caries Experience - Total number of Affected Tooth Surfaces of Permanent and Primary Teeth of 688 Children of Migrant Families, Ages 2-15 years, 1970

Age	No. Children	Permanent Teeth "D" Surfaces	Permanent Teeth "M" Surfaces	Permanent Teeth "F" Surfaces	Permanent Teeth Total DMF Surfaces	Primary Teeth "d" Surfaces	Primary Teeth "e" Surfaces	Primary Teeth "f" Surfaces	Primary Teeth Total def Surfaces
2	10	-	-	-	-	24	0	0	24
3	17	-	-	-	-	102	0	0	102
4	76	2	0	0	2	363	65	8	436
5	113	12	0	0	12	599	130	213	942
6	130	113	0	14	127	731	240	245	1216
7	96	197	5	60	262	521	210	347	1078
8	104	258	50	93	401	368	125	461	954
9	55	138	25	63	226	195	55	161	411
10	49	153	30	107	290	110	35	127	272
11	20	80	10	70	160	44	5	25	74
12	10	29	10	35	74	13	0	0	13
13	7	41	0	0	41	-	-	-	-
14	0	-	-	-	-	-	-	-	-
15	1	5	0	0	5	-	-	-	-
Total	688	1028	130	442	1600	3070	865	1587	5522

DE 9/70

TABLE 6

DENTAL HEALTH SECTION

Dental Caries Experience - Average Number of Tooth Surfaces (Rate per child) of Permanent and primary Teeth of 688 Children of Migrant Families, Ages 2 - 15 years, 1970

Age	No. Children	Permanent Teeth "D" Surfaces	Permanent Teeth "M" Surfaces	Permanent Teeth "F" Surfaces	Permanent Teeth Total DMF Surfaces	Permanent Teeth F/DMF Surfaces	Primary Teeth "d" Surfaces	Primary Teeth "e" Surfaces	Primary Teeth "f" Surfaces	Primary Teeth Total def Surfaces	Primary Teeth f/def Surfaces
2	10	-	-	-	-	-	2.40	0	0	2.40	0%
3	17	-	-	-	-	-	6.00	0	0	6.00	0
4	76	.026	0	0	.026	0%	4.78	.85	.11	5.74	1.8%
5	113	.106	0	0	.106	0	5.30	1.15	1.88	8.33	22.6
6	130	.869	0	.108	.977	11.0	5.62	1.85	1.88	9.35	20.1
7	96	2.05	.053	.625	2.73	22.9	5.43	2.19	3.61	11.23	32.2
8	104	2.48	.481	.894	3.85	23.2	3.54	1.20	4.43	9.17	48.3
9	55	2.51	.455	1.15	4.11	27.9	3.54	1.00	2.93	7.47	39.2
10	49	3.12	.612	2.18	5.91	36.9	2.24	.72	2.59	5.55	46.7
11	20	4.00	.50	3.50	8.00	43.8	2.20	.25	1.25	3.70	33.8
12	10	2.90	1.00	3.50	7.40	47.3	1.30	0	0	1.30	0
13	7	5.86	0	0	5.86	0	-	-	-	-	-
14	0	-	-	-	-	-	-	-	-	-	-
15	1	5.00	0	0	5.00	0	-	-	-	-	-
Total	688										

DE 9/70

TABLE 7

DENTAL HEALTH SECTION
Dental Caries Experience - Total Number of Affected
Permanent and Primary Teeth as observed in Head Start Children,
Ages 2-10,1970

		Permanent Teeth				Primary Teeth			
Age	No. Children	"D" Teeth	"M" Teeth	"F" Teeth	Total DMF Teeth	"d" Teeth	"e" Teeth	"f" Teeth	Total def Teeth
2	1	-	-	-	-	0	0	0	0
3	11	-	-	-	-	18	0	0	18
4	62	-	-	-	-	201	11	33	245
5	79	6	0	0	6	312	20	70	402
6	56	27	0	15	42	160	41	82	283
7	4	6	0	0	6	17	0	6	23
8	0	-	-	-	-	-	-	-	-
9	1	0	0	0	0	0	0	0	0
10	1	0	0	0	0	0	0	0	0
Total	215	39	0	15	54	708	72	191	971

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TABLE 8

DENTAL HEALTH SECTION
Dental Caries Experience (Rate per child) in permanent and primary teeth of 215
Head StartChildren , ages 2 - 10 years of age, 1970

		Permanent Teeth					Primary Teeth				
Age	No. Children	"D" Teeth	"M" Teeth	"F" Teeth	Total DMF Teeth	F/DMF %	"d" Teeth	"e" Teeth	"f" Teeth	Total def Teeth	f/def %
2	1	-	-	-	-	-	0	0	0	0	0
3	11	-	-	-	-	-	1.64	0	0	1.64	0
4	62	-	-	-	-	-	3.24	.18	.53	3.95	13.5%
5	79	.076	0	0	.076	0%	3.95	.25	.89	5.09	17.4
6	56	.48	0	.27	.75	35.7	2.86	.73	1.46	5.05	29.0
7	4	1.5	0	0	1.5	0	4.25	0	1.5	5.75	26.1
8	0	-	-	-	-	-	-	-	-	-	-
9	1	0	0	0	0	0	0	0	0	0	0
10	1	0	0	0	0	0	0	0	0	0	0
Total	215	.18	0	.07	.25	27.8%	3.29	.33	.89	4.52	19.7%

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TABLE 9

DENTAL HEALTH SECTION

Dental Caries Experience - Total Number of Affected Tooth Surfaces of Permanent and Primary Teeth of 215 Head Start Children, Ages 2 - 10, 1970

		Permanent Teeth				Primary Teeth			
Age	No. Children	"D" Surfaces	"M" Surfaces	"F" Surfaces	Total DMF Surfaces	"d" Surfaces	"e" Surfaces	"f" Surfaces	Total def Surfaces
2	1	-	-	-	-	0	0	0	0
3	11	-	-	-	-	20	0	0	20
4	62	-	-	-	-	280	55	61	396
5	79	6	0	0	6	441	100	123	664
6	56	27	0	23	50	238	205	177	620
7	4	8	0	0	8	29	0	15	44
8	0	-	-	-	-	-	-	-	-
9	1	0	0	0	0	-	-	-	-
10	1	0	0	0	0	-	-	-	-
Total	215	41	0	23	64	1008	360	376	1744

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TABLE 10

DENTAL HEALTH SECTION

Dental Caries Experience - Average Number of Tooth Surfaces (Rate per Child) of Permanent and Primary Teeth of 215 Head Start Children, Ages 2 - 10, 1970

		Permanent Teeth					Primary Teeth				
Age	No. Children	"D" Surfaces	"M" Surfaces	"F" Surfaces	Total DMF Surfaces	F/DMF Surfaces	"d" Surfaces	"e" Surfaces	"f" Surfaces	Total def Surfaces	f/def Surfaces
2	1	-	-	-	-	-	0	0	0	0	0
3	11	-	-	-	-	-	1.82	0	0	1.82	0%
4	62	-	-	-	-	-	4.52	.89	.98	3.69	15.4
5	79	.076	0	0	.076	0%	5.58	1.27	1.56	8.41	18.5
6	56	.482	0	.411	.893	46.0	4.25	3.66	3.16	11.07	28.5
7	4	2.00	0	0	2.00	0	7.25	0	3.75	11.00	34.1
8	0	-	-	-	-	-	-	-	-	-	-
9	1	0	0	0	0	0	0	0	0	0	0
10	1	0	0	0	0	0	0	0	0	0	0
Total	215										

[illegible] 9/10/70

TABLE 11

DENTAL HEALTH SECTION
Dental Caries Experience - Total Number of Affected
Permanent and Primary Teeth as Observed in Remedial School Children
Ages 2-14, 1970

Age	No. Children	Permanent Teeth "D" Teeth	Permanent Teeth "M" Teeth	Permanent Teeth "F" Teeth	Permanent Teeth Total DMF Teeth	Primary Teeth "d" Teeth	Primary Teeth "e" Teeth	Primary Teeth "f" Teeth	Primary Teeth Total def Teeth
2	3	-	-	-	-	3	0	0	3
3	7	-	-	-	-	29	0	0	29
4	2	-	-	-	-	5	0	0	5
5	8	-	-	-	-	20	0	22	42
6	16	10	0	0	10	38	4	34	76
7	27	29	0	6	35	60	15	68	143
8	38	55	1	31	87	91	15	119	225
9	23	38	0	27	65	39	0	74	113
10	21	37	2	31	70	27	3	57	87
11	12	19	0	18	37	5	0	13	18
12	12	32	0	29	61	1	0	8	9
13	0	-	-	-	-	-	-	-	-
14	1	2	0	2	4	2	0	1	3
Total	170	222	3	144	369	320	37	396	753

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TABLE 12

DENTAL HEALTH SECTION
Dental Caries Experience (Rate per child) in permanent and primary teeth of 170 Remedial Children, Ages 2 - 14, 1970

Age	No. Children	Permanent Teeth "D" Teeth	Permanent Teeth "M" Teeth	Permanent Teeth "F" Teeth	Permanent Teeth Total DMF Teeth	Permanent Teeth F/DMF %	Primary Teeth "d" Teeth	Primary Teeth "e" Teeth	Primary Teeth "f" Teeth	Primary Teeth Total def Teeth	Primary Teeth f/def %
2	3	-	-	-	-	-	1	0	0	1	0%
3	7	-	-	-	-	-	4.14	0	0	4.14	0
4	2	-	-	-	-	-	2.5	0	0	2.5	0
5	8	-	-	-	-	-	2.5	0	2.75	5.25	52.4%
6	16	.63	0	0	.63	6%	2.38	.25	2.13	4.75	44.7
7	27	1.07	0	.22	1.30	17.1	2.22	.56	2.52	5.30	47.6
8	38	1.45	.03	.82	2.29	35.6	2.39	.39	3.13	5.92	52.9
9	23	1.65	0	1.17	2.83	41.3	1.70	0	3.22	4.91	65.5
10	21	1.76	.10	1.48	3.33	44.3	1.29	.14	2.71	4.14	65.5
11	12	1.58	0	1.5	3.08	48.6	.42	0	1.08	1.5	72.2
12	12	2.67	0	2.42	5.08	47.5	.08	0	.67	.75	88.9
13	0	-	-	-	-	-	-	-	-	-	-
14	1.0	2.0	0	2.0	4.0	50	2.0	0	1.0	3.0	33.3
Total	170	1.31	.02	.85	2.17	39.06	1.88	.22	2.33	4.43	52.64

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TABLE 13

DENTAL HEALTH SECTION
Dental Caries Experience - Total Number of Affected Tooth Surfaces of Permanent and Primary Teeth
of 170 Remedial Children, Ages 2 - 14 years, 1970

Age	No. Children	"D" Surfaces	"M" Surfaces	"F" Surfaces	Total DMF Surfaces	:	"d" Surfaces	"e" Surfaces	"f" Surfaces	Total def Surfaces
2	3	-	-	-	-	:	3	0	0	33
3	7	-	-	-	-	:	43	0	0	43
4	2	-	-	-	-	:	6	0	0	6
5	8	-	-	-	-	:	28	0	42	70
6	16	10	0	0	10	:	49	20	77	146
7	27	32	0	18	50	:	90	75	132	297
8	38	73	5	58	136	:	142	75	337	554
9	23	49	0	48	97	:	69	0	165	234
10	21	51	10	57	118	:	37	15	111	163
11	12	21	0	32	53	:	7	0	33	40
12	12	45	0	56	101	:	2	0	20	22
13	0	-	-	-	-	:	-	-	-	-
14	1	3	0	5	8	:	3	0	3	6
Total	170	284	15	274	573	:	479	185	920	1584

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TABLE 14

DENTAL HEALTH SECTION
Dental Caries Experience - Average Number of Tooth Surfaces (Rate per child) of
Permanent and Primary Teeth of 170 Remedial Children, Ages 2-14, 1970

		: Permanent Teeth					: Primary Teeth				
Age	No. Children	"D" Surfaces	"M" Surfaces	"F" Surfaces	Total DMF Surfaces	F/DMF Surfaces	: "d" Surfaces	"e" Surfaces	"f" Surfaces	Total def Surfaces	f/def Surfaces
2	3	-	-	-	-	-	: 1.00	0	0	1.00	0%
3	7	-	-	-	-	-	: 6.14	0	0	6.14	0
4	2	-	-	-	-	-	: 3.00	0	0	3.00	0
5	8	-	-	-	-	-	: 3.50	0	5.25	8.75	60.0
6	16	.625	0	0	.625	0%	: 3.06	1.25	4.81	9.12	52.7
7	27	1.19	0	.667	1.86	36.0	: 3.33	2.78	4.89	11.00	44.4
8	38	1.92	.132	1.53	3.58	42.6	: 3.74	1.97	8.87	14.58	60.8
9	23	2.13	0	2.09	4.22	49.5	: 3.00	0	7.17	10.17	70.5
10	21	2.43	.476	2.71	5.62	48.3	: 1.76	.714	5.29	7.76	68.1
11	12	1.75	0	2.67	4.42	60.4	: .583	0	2.75	3.33	82.5
12	12	3.75	0	4.67	8.42	55.4	: .167	0	1.67	1.84	90.9
13	0	-	-	-	-	-	: -	-	-	-	-
14	1	3.00	0	5.00	8.00	62.5	: 3.00	0	3.00	6.00	50.0
Total	170										

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TABLE 15

MIGRANT CAMPS - SCREENING CLASSIFICATION
(#4 Tongue Blade Exam)

Age	# of Children	DMF/def Total	DMF/def Average	# Of 0's	% of 0's	# of 1 & 2's	% of 1 & 2's	# of 3 & 4's	% of 3 & 4's
0-4	100	223	2.23	43	43.0	46	46.0	11	11.0
5	52	219	4.21	8	15.4	31	59.6	13	25.0
6	50	247	4.94	6	12.0	34	68.0	10	20.0
7	56	281	5.02	6	10.7	35	62.5	15	26.8
8	59	325	5.51	5	8.5	40	67.8	14	23.7
9	63	293	4.65	7	11.1	45	71.4	11	17.5
10	75	291	3.88	9	12.0	52	69.3	14	18.7
11	57	190	3.33	7	12.3	40	70.2	10	17.5
12	60	217	3.62	7	11.7	48	80.0	5	8.3
13	55	221	4.02	5	9.1	41	74.5	9	16.4
14	43	198	4.60	3	7.0	31	72.1	9	20.9
15	30	131	4.37	5	16.7	21	70.0	4	13.3
16-21	80	451	5.64	2	2.5	51	63.7	27	33.8
22+	165	1166	7.07	8	4.8	70	42.5	87	52.7
TOTAL	945	4453	4.71	121	12.8	585	61.9	239	5.3

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DENTAL HEALTH SECTION
COMPARISON OF SELECT AGE GROUPS
AS RELATED TO URGENCY OF DENTAL CARE NEEDS

TABLE 16

	HEAD START							REMEDIAL							MIGRANT						
Age	No.	0	%	1-2	%	3-4	%	No.	0	%	1-2	%	3-4	%	No.	0	%	1-2	%	3-4	%
1																					
2	1	1	100%	0	0%	0	0%	3	2	66.7%	1	33.3%	0	0%	10	5	50.0	4	40 %	1	10 %
3	11	7	63.6	4	36.4	0	0	7	2	28.6	5	71.4	0	0	17	5	29.4	9	52.9	3	17.7
4	62	23	37.1	27	43.5	12	19.4	2	1	50.	1	50.	0	0	76	24	31.6	39	51.3	13	17.1
5	79	18	22.8	48	10.8	13	16.4	8	2	25.	5	62.5	1	12.5	113	24	21.3	64	56.6	25	22.1
6	56	16	28.6	28	50.0	12	21.4	16	4	25.	9	56.2	3	18.8	130	21	16.2	77	59.2	32	24.6
7	4	1	25.	3	75.	0	0	27	3	11.1	18	66.7	6	22.2	96	16	16.7	56	58.3	24	25.0
8	0	-	-	-	-	-	-	38	8	21.0	21	55.3	9	23.7	104	19	18.3	63	60.6	22	21.1
9	1	1	100	0	0	0	0	23	7	30.4	13	56.5	3	13.1	55	11	20.0	33	60.0	11	20.0
10	1	1	100	0	0	0	0	21	5	23.8	14	66.7	2	9.5	49	8	16.3	36	73.5	5	10.2
11								12	7	58.3	3	25.	2	16.7	20	2	10.0	17	85.0	1	5.0
12								12	2	16.7	8	66.6	2	16.7	10	3	30.0	5	50.0	2	20.0
13								0	-	-	-	-	-	-	7	1	14.3	4	57.1	2	28.6
14								1	0	0	1	100	0	0	0	-	-	-	-	-	-
15															1	0	0	1	100	0	0
Total	215	68	31.6%	110	51.2%	37	17.2	170	43	25.3%	99	58.2%	28	16.5%	688	139	20.2%	408	59.3%	141	20.5%

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TABLE 17

COMPARISON OF SELECTED AGE GROUPS
AS RELATED TO
ORAL HYGIENE INDEX

AGE	MIGRANT	HEAD START	OTHER
2	1.18	0.67	-
3	1.26	1.08	1.25
4	1.26	1.23	1.17
5	1.34	1.25	1.42
6	1.32	1.36	1.37
7	1.51	1.75	1.27
8	1.30	-	1.54
9	1.52	1.67	1.51
10	1.54	1.83	1.32
11	1.29	-	1.51
12	1.53	-	1.71
13	1.59	-	-
14	-	-	1.50
15	1.00	-	-